Making Local Healthcare Equal: Healthcare Concerns in Black and Asian Communities

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healthwatch Hertfordshire

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Foreword

I am incredibly proud to introduce this ground-breaking research, which is a first for Hertfordshire and will lead the way in tackling ethnic health inequalities across the county.

Our research has shown that almost one in two Black and Asian people who responded to us felt they had been discriminated against in a healthcare setting, with many believing this was because of their ethnicity.

This is a shocking finding which demonstrates just how important it is that we have delved into the issue of ethnic health inequalities across the region.

It has given a much-needed voice to local Black and Asian communities, who have entrusted us with their views and experienced of healthcare and provided a rare insight into the deep issues underlying their concerns.

Encouragingly, local NHS organisations have responded to the findings in this report and our recommendations with a strong commitment to work alongside us and Black and Asian communities to tackle these inequalities.

The NHS is aware that the scale of this challenge is enormous and resolving issues will require long-term commitment, which we will closely monitor.

Unfortunately, ethnic health inequalities are nothing new and the true scale of these became apparent during the COVID-19 pandemic, which is what prompted us to look at the situation locally.

In preparing for this research, we spent months working with Black and Asian communities to build trusting, ongoing relationships that allowed people to feel safe sharing their views and experiences with us.

As an organisation, we are committed to seeking out and listening to seldom heard voices throughout our community and we will work to maintain the valuable relationships we have built into the future.

We are also reviewing or own Equality, Diversity and Inclusion policies and procedures in light of the evidence presented here, including our engagement, communication and recruitment strategies to ensure we adopt best practice as an organisation.

We look forward to working with local Black and Asian communities, NHS organisations and care providers to monitor the recommendations we have made in this report, and through our holding to account role, will ensure changes occur.

Finally, we want to sincerely thank all of those who agreed to take part and share their stories with us for this research. By airing their views and concerns, which may have been hidden before, they have played a crucial part in helping to improve local services.

Steve Palmer, Chair of Healthwatch Hertfordshire

Executive Summary

Ethnic health inequalities mean Black and Asian people may not always receive equal and fair treatment from healthcare services. We want to work with local services to tackle this inequality and help ensure everybody receives the same level of care, regardless of race, ethnicity, religion or culture.

This report is a first of its kind which, on a local level, explores the views and experiences of local healthcare amongst Black and Asian Hertfordshire residents.

We worked closely with Black and Asian community leaders to understand how best to engage with Black and Asian Hertfordshire residents, and to ensure our methodologies were culturally competent and provided a safe space for people to share their views. Using their insight and guidance, we ran focus groups, interviews and an online survey. In total we heard from **156** Black and Asian Hertfordshire residents.

Key Findings: Black and Asian Hertfordshire residents

Although experiences differed, people typically felt that the healthcare system was not designed to deliver fair and culturally competent care. Respondents shared experiences of not being listened to and feeling discriminated against, which for many contributed to a significant lack of trust in the healthcare system to provide adequate and person-centred care.

44% of respondents felt that their health **is not** equally protected by the NHS compared to the health of a White person.

Mistrust in the NHS stems from many places, including their own, or their family and friends' negative lived experience, the disproportionate impact of COVID-19 on Black and Asian communities, and the existence of ethnic health inequalities more broadly.

45% of respondents felt they had been **discriminated** against in a healthcare setting, with many believing this was because of their ethnicity. Experiences included the use of racial stereotypes and mistreatment from healthcare professionals. Respondents felt that as a result, they were not listened to and had their healthcare concerns dismissed in a way that their White counterparts would not, resulting in mistrust and a reluctance to engage with healthcare services.

Respondents felt that healthcare professionals do not always have an adequate understanding of conditions that primarily affect Black and Asian people, or how conditions may present on darker complexions. Respondents felt that this resulted in late or incorrect diagnoses.

A lack of cultural competency in care meant dietary, language, religious and cultural needs and preferences were not always respected or accommodated.

Key Findings: NHS Providers and Commissioners

We interviewed senior staff within local NHS trusts, as well as staff from the Clinical Commissioning Groups (CCGs) that were in place prior to the Integrated Care System (ICS) being established. Providers and commissioners talked about their Equality, Diversity and Inclusion policies and how specifically they are working to tackle ethnic health inequalities. Although all Trusts and CCGs emphasised a strong commitment to tackling ethnic inequality, more work needs to be done to provide equal and fair care to all patients.

- NHS policies and strategies often do not address ethnicity specifically, and do not look at the specific needs of Black and Asian communities.
- Training on cultural competency within the NHS is limited, and not offered to all staff.
- Language preferences are often not recorded and translation support is not always forthcoming from healthcare professionals.
- Communications often homogenise all ethnic groups by using collective terminology, such as 'BAME'.
- The recording and collection of patient ethnicity data by NHS services is inconsistent and is not often used to highlight where health disparities may exist for Black and Asian communities.
- NHS services do not directly engage with local Black and Asian communities, preventing services from understanding their needs and experiences.

We made **16** recommendations to Hertfordshire's healthcare providers and commissioners, as well as learning for the Hertfordshire and West Essex ICS and local Health and Care Partnerships.

Responses to the recommendations are detailed in the full report and outline how services will respond to the needs and cultural preferences of Black and Asian patients to provide fairer care and to tackle ethnic health inequalities.

About Healthwatch Hertfordshire

Healthwatch Hertfordshire (HwH) represents the views of people in Hertfordshire for health and social care services. We provide an independent consumer voice for evidencing patient and public experiences and gathering local intelligence with the purpose of influencing service improvement across the county. We work with those who commission, deliver and regulate health and social care services to ensure the people's voice is heard, and to address gaps in services quality and/or provision.

Background

National Context

Ethnic inequalities in healthcare have existed for many years. However, the COVID-19 pandemic and the Black Lives Matter movement have shown how this inequality has only worsened, meaning it has never been more important to hear directly from those affected, and to ensure tackling ethnic health inequalities is prioritised.

National data shows that Black and Asian people experience significantly poorer healthcare outcomes compared to their White counterparts. Examples of this include, but are not limited to:

- Black women are four times more likely to die in childbirth than White women, and Asian women are almost twice as likely.[1]
- In the first half of 2020, Black people were almost four times more likely to die from COVID-19 than White people. Figures were more varied for Asian people, dependent on their specific ethnicity, but it remained that death from COVID was statistically higher compared to their White counterparts.[2]
- Black men are four times more likely than White men to be detained under the Mental Health Act,[3] and are more likely to access treatment through the criminal justice system rather than seeking help of their own accord. [4]
- People from South Asian communities are up to six times more likely to have Type 2 Diabetes than the general population. [5]

Black and Asian people are also more likely to feel undervalued and mistreated by the NHS, noting incidences of discrimination, and their culture and ethnicity not being acknowledged or respected by healthcare professionals when accessing care.

There is a deep mistrust in the NHS amongst Black and Asian people, particularly within Black communities with recent work by Clear View Research[6] finding that 78% of Black women and 47% of Black men do not believe that their health is equally protected by the NHS in comparison to that of White people.

[1] Knight M, Bunch K, Tuffnell D, Patel R, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2021.

[2] ONS (2020). *Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England and Wales: deaths occurring 2 March to 28 July 2020.* [online]. Available at: Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England and Wales - Office for National Statistics (ons.gov.uk)

[3] GOV.UK (2021). *Detentions under the Mental Health Act.* [online]. Available at: Detentions under the Mental Health Act - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

[4] GOV.UK (2018). *Modernising the Mental Health Act: Increasing choice, reducing compulsion.* [online]. Available at: Modernising the Mental Health Act: Final Report of the Independent Review of the Mental Health Act 1983 (publishing.service.gov.uk)

[5] Diabetes.co.uk (2018). *Diabetes in South Asians.* [online]. Available at: Diabetes in South Asians

[6] [6] Henry, C, Imafidon, K & McGarry, N. (2020). CVR Insights. The Black Community and Human Rights. Available at: The-Black-Community-Human-Rights-Report.pdf (parliament.uk)

With national evidence highlighting the extent and severity of ethnic health inequalities, it is essential that organisations come together to ensure that the healthcare system is fair and equal, and that everybody, regardless of race, ethnicity, culture or religion, receives the care they need and deserve.

Local Context

According to the 2011 ONS Census Data, in Hertfordshire, approximately 9.3% of the population are from a Black (2.8%) or Asian (6.5%) background, and it is likely that this figure has increased since.

Despite this and the statistics surrounding ethnic health inequalities, there is very limited data both nationally and locally, that systematically seeks to understand how local Black and Asian communities' access, use and experience healthcare services. An understanding of this will add value through services that are culturally competent and work effectively for all patients.

Previous Engagement

This work builds on previous engagement with Black and Asian community leaders, where discussions focused on key healthcare concerns and priorities for different communities, as well as how services can work to engage better with groups who often feel that their voice is not heard. As part of this work, leaders identified a need to look at health inequalities more broadly, rather than focusing on singular issues, such as uptake of the COVID-19 vaccine. More information about this previous engagement, and how it informed this project, can be found here.

Aims

The aims of this project were:

- To obtain a better understanding of the health experiences and perceptions of local Black and Asian communities to inform services and commissioning.
- To gather evidence relating to Black and Asian experiences of health care and how this might differ from the general population, to support the improvement of services.
- To work with NHS partners to improve the equality and inclusivity of their services for Black and Asian communities.
- To make recommendations to health and social care bodies on how they can work to tackle ethnic health inequalities and build trust with Black and Asian communities.
- To build trusting, ongoing relationships with Black and Asian communities to allow them to feel safe sharing their views and experiences with us, both for this project and in the future.

Methodology

Engagement with Black and Asian Communities

Online Survey

To understand Black and Asian people's views towards, and experiences of, local healthcare, we launched an online survey. This was designed with, and reviewed by, local Black and Asian community leaders to ensure that the language and survey questions were sensitive and culturally appropriate.

The online survey was available in 10 languages[7], based on advice from Black and Asian community leaders on which languages are most commonly spoken in Hertfordshire. Respondents could request the survey in different formats and languages if required. As ethnic groups should not be homogenised, we created two versions of the survey; one for Black Hertfordshire residents and one for Asian Hertfordshire residents, and ensured that the language used within each survey was appropriate.

The survey focused on the following themes:

- Attitudes towards the NHS
- Trust and confidence in the NHS
- Communication and support
- Experiences of specific NHS services
- Equality in healthcare between ethnic groups

The survey was distributed through our social media channels and shared with partner organisations, as well as 42 community and faith groups within local Black and Asian communities. The survey was open from November 2021 to May 2022 and in total we heard from 85 Black and Asian Hertfordshire residents.

Interviews and Focus Groups

To enable Black and Asian communities to share their experiences in more detail, we held one-to-one interviews and focus groups. For consistency, the focus group and interview questions replicated the themes asked in the online survey. Focus groups were held in collaboration with Black Voice Letchworth, RCCG Pavilion of Redemption Church, Watford FC Community Sports & Education Trust and African Caribbean Senior and Carers Lunch Club. All, with the exception of one, were held face-to-face. In total we engaged with 60 Black and Asian Hertfordshire residents.

11 people from Black and Asian communities took part in a one-to-one interview which were carried out over the phone. This feedback, along with the focus groups, were incorporated into the survey findings. In total, we engaged with 156 Black and Asian people.[8]

<u>Engagement with Senior NHS Staff</u>

In July 2022, the Hertfordshire and West Essex Integrated Care System (ICS) was formally established, effectively dissolving the Clinical Commissioning Groups (CCGs) that were in place at the time of engagement. During this time, the ICS was still in development. We therefore interviewed senior NHS staff at Trusts and CCGs in Hertfordshire, but not the ICS. The Trusts and CCGs we engaged with were:

- West Hertfordshire Teaching Hospitals NHS Trust (WHTH)
- East and North Hertfordshire Hospitals NHS Trust (ENHHT)
- Hertfordshire Partnership University Foundation NHS Trust (HPFT)
- Central London Community Healthcare NHS Trust (CLCH)
- Hertfordshire Community NHS Trust (HCT)
- East and North Hertfordshire CCG (ENHCCG)
- Herts Valleys CCG (HVCCG)

[7] The survey languages readily available were: English, French, Tamil, Arabic, Farsi, Gujarati, Chinese, Bengali, Urdu and Punjabi.

[8] Throughout this report, we have stated respondents' self-identified ethnicity. For example, some people identified as 'Indian' and other people identified as 'British Indian'.

The interviews aimed to understand how the NHS is supporting the needs of local Black and Asian communities, and improving the quality of care these communities receive, through capturing:

- Governance and policies relating to Black and Asian communities
- The collection and use of patient ethnicity data
- The gathering of feedback and complaints from Black and Asian groups
- How cultural competency is cultivated across services
- Barriers to engaging with Black and Asian communities
- Examples of best practice and learning
- Plans and interventions for reducing health inequalities for Black and Asian groups

Limitations, Learning and Value Added

Limitations

- Despite offering the option of providing the survey in alternative formats, all respondents completed the survey online. This suggests that most respondents were likely to have access to, and feel competent using, online technology, and can't represent the views of digitally excluded people who mat
- National evidence and our previous engagement with Black and Asian community leaders highlighted that Black and Asian groups are often reluctant to engage with public bodies due to feelings of mistrust, which could have affected the response rate, despite us emphasising our independence.
- Within the online survey, respondents answered service specific questions based on them indicating that they had used this service. In some instances, we received low response rates to these questions. As such responses cannot be seen as representative, we pulled themes on these topics from our other engagement methods, where data was richer.
- Respondents gave their views or shared their experiences from their own perspectives. We included these experiences with the understanding that they cannot always be evidenced with data from other sources, but with the recognition that these experiences are important, and provide valuable insight into understanding people's views of the NHS which must be addressed.
- Similarly, some experiences may not be recent, and pathways or communications improved since. However, these experiences remain important when considering the impact on patient confidence and trust.

Learning and Value Added

- This report is a first of its kind, looking at the experiences of, and attitudes towards, local healthcare within Black and Asian communities in Hertfordshire. This research adds value by capturing the lived experience and voices of local Black and Asian groups, which have previously been unheard.
- Due to communities feeling that their contributions are not valued, building trust was a core component of this work. We developed ongoing relationships with community leaders and their communities, and ensured that the research was informed by their views and feedback. We recognised that trust-building required a lot of time and should not be rushed. For that reason, we extended our engagement period from 3 months to 6 months, to build trust and boost our response rate.

- Not only do contributions need to be valued, but engagement needs to be continuous to build long-lasting, trusting relations between services and communities. Continuous engagement shows communities that they are valued, rather than being engaged just because it suits an organisation's agenda. We have made sure to keep stakeholders updated at all stages of this research, and will continue working with community leaders on future projects. These relationships, and the voice of communities, will be invaluable as we continue our work on tackling ethnic health inequalities.
- This piece of work focused on the NHS within Hertfordshire, but the learning has a broader reach and is also relevant for social care partners and ourselves at HwH. We are currently reviewing our Equality, Diversity and Inclusion policies and procedures in light of the evidence to ensure we are equal, inclusive and culturally competent as an organisation.

Key Findings: Views and Experiences of Black and Asian Communities

Introduction

This paper covers complex topics, rooted in both history and personal lived experience, and should be considered within the wider societal context of inequality and systemic discrimination[9]. Black and Asian people's mistrust is often not unique to the NHS, but extends across a range of public bodies. This context is important when understanding how mistrust may have grown so deep for people, regardless of whether they have had a particularly negative healthcare experience.

As Black and Asian people's experiences are varied and often raise more than one single issue, at times there is an overlap between the themes in this paper, highlighting the complexity of the issues at hand. This overlap is seen when considering intersectionality in particular, for example, some respondents felt discriminated against, but could not be certain if this was due to their race, or other factors, such as their gender or age.

> *"Felt not taken seriously – whether this was to do with gender, colour, appearance I am unsure. However, there was some bias."* (Indian ethnicity)

> *"A member of staff at the hospital seemed to take a disliking to me and made that clear and it felt like it was because of my race but I can't say that for certain."* (Indian ethnicity)

> *"I'm not sure ethnic background has ever had an effect on the application or provision of healthcare – I do, however, see age, particularly in women, as being an issue with regard to being listened to, and *heard*."* (Black Caribbean ethnicity)

The complexity of identity and experience means that there should not be a 'one-size-fits-all' approach to addressing the issues that Black and Asian Hertfordshire residents shared with us. However, this paper aims to capture the lived experience of Black and Asian communities, and support NHS services in providing culturally competent care that better serves and meets the needs of Black and Asian people.

Mistrust in Healthcare

Events over recent years have highlighted, and exacerbated, not only ethnic health inequalities, but also a distinct lack of trust in the NHS amongst Black and Asian people. The views and experiences that respondents shared with us show that this lack of trust is also felt by Black and Asian Hertfordshire residents, with 44% of survey respondents 'disagreeing' or 'strongly disagreeing' that the NHS protects their health as equally as it protects the health of a White person.

Differences are seen between groups, with Black respondents considerably more likely to 'strongly disagree' than Asian respondents when thinking about the NHS generally (47% versus 6% respectively). In fact, Black respondents were more likely to 'strongly disagree' with this statement in relation to all services compared to

[9] Systemic discrimination, or systemic racism, refers to policies and practices that exist in organisations or society that provide an unfair disadvantage to majority groups and put minority groups at a disadvantage.

Asian respondents[10]. For example, when asked about GP services, only 5% of Asian respondents 'disagreed' or 'strongly disagreed' with the statement in comparison to 40% of Black respondents.

This was also highlighted in interviews, with 64% of respondents stating they believed the NHS protects the health of a White person better than that of a Black or Asian person. In interviews, Asian respondents were as likely as Black respondents to feel this way.

When respondents were asked why they felt that their health was not equally protected, people typically talked about feeling discriminated against, not being listened to and poor experiences when accessing healthcare services.

> *"Speaking to me in a patronising way? Not respecting my culture? Not addressing my needs? Well frankly it's because I'm not white, isn't it?"* (Black Caribbean ethnicity)

> *"I think the white person will always be treated better. There are microaggressions and you know, small things like rolling eyes when I'm speaking or getting impatient. You know it might be called racism but it's not nice."* (British Pakistani ethnicity)

> *"The way that I have been treated, if I was a British or UK citizen, never ever they dare to do these kinds of things against me. But certainly this is the case. Certainly."* (Iranian ethnicity)

> *"If I was White I would be treated differently and most likely better."* (Indian ethnicity)

> *"White people are obviously favoured. Whether it is intentional it happens and it happens a lot."* (Black African ethnicity)

> *"We are automatically labelled aggressive when we are frustrated but our white counterparts are labelled upset for the same behaviours. We have to wait longer, get less information and a different tone of voice or attitude generally too. No care and consideration like our white counter parts."* (Black Caribbean and White)

58% of respondents said that their previous experiences of healthcare services had decreased their levels of trust and confidence in the NHS. Here, differences between Black and Asian groups were smaller, with 68% of Black respondents and 50% of Asian respondents noting a decline. Respondents gave examples of how their symptoms weren't taken seriously or that they experienced problems with receiving a diagnosis. Only 15% of respondents said their previous experiences had increased their trust and confidence.

> *"Experience with my mother, who was diagnosed with cancer far too later, therefore unable to treat. Poor service from GP and hospital staff."* (Bangladeshi ethnicity)

[10] Services we asked about: GP, pharmacy, dentistry, hospital services, mental health services, sexual health services, community services.

"My wife had gallstones which was causing immense pain for 3 weeks and this could not be diagnosed due to lack of staff training, casual attitudes towards the issue, GP was deplorable as he wouldn't even do anything." (Indian ethnicity)

"I've also seen relatives access health and support and be mistreated or misdiagnosed…this doesn't encourage trust or the belief that my health is equally protected by the NHS." (Black Caribbean ethnicity.)

"I am suffering with pain in my left side for around three years now. I ask my doctor if it would be possible to take a scan to find out what happened, all my doctor told me that it's a pulled muscle. My partner did have the same problem and they said the same thing to him, then it works out to be cancer, so I don't put my trust in the hospital or my GP doctor." (Black British ethnicity)

However, it was not always a poor experience that impacted someone's level of trust and confidence in the NHS. A number of respondents said their trust in the NHS had been affected by the existence of ethnic health inequalities generally, and the poor treatment that other people in their communities have received. This demonstrates how issues of trust within the NHS may not be because of an individual's own experience, but due to the wider societal context of inequality.

"…the female mortality rates during the labour for Black women…I think people are scared if they do go to a white doctor when they go into labour that they won't come out alive." (Black ethnicity)

"My past experiences haven't necessarily impacted [my trust] but my learning has impacted the way I feel about the NHS. I don't believe the NHS is for any particular person anymore. I feel that they're there to meet their targets, follow their policies, regardless of the person. So I guess when I would have said yes I completely trust the NHS, I don't anymore." (Black ethnicity)

"They're just saying "ugh, minorities don't take [the vaccine]." It's not true. There is history behind why people were used for experiments in the 20s and 30s and that's why it's driven this culture of not trusting science. And people need to understand that. But again, there's not always a wider understanding." (Indian ethnicity)

"There is a lot of inequality in the service provided to the Asian community." (Bangladeshi ethnicity)

For some respondents, their mistrust in the NHS extended as far as avoiding accessing healthcare or receiving medical treatment unless absolutely necessary. This has the potential to leave medical conditions undiagnosed and untreated, impacting an individual's health and quality of life.

"Literally, it's between life and death. That's really the only time you go to a doctor…Because you used to say that Western medicine will kill you, literally. But I think that stems from a lot of things. I think it stems from the historical aspects of our relationship with that's now considered Westernised medicine." (Black ethnicity)

"Statistically within the NHS racial bias, discrimination, racism toward black people is norm. It has been this way since the NHS existed with experiences of it being passed down from generation to generation in our community and sustained by the lived experience of the average Black person today. Access to these services are only for absolute necessity." (Black Caribbean ethnicity)

For other respondents, the COVID-19 pandemic contributed to their lack of trust, with 50% of survey respondents sharing that their perception of the NHS has changed negatively since the pandemic. This was often due to respondents experiencing lower standards or care, but also due to recognising that Black and Asian people had been disproportionately affected by COVID-19.

"Statistics show more people from the BAME community have died as a result of covid. They have been disproportionately impacted." (Bangladeshi ethnicity)

"I think the pandemic has shown just how bad ethnic minorities can be treated. Whether or not it is intentional doesn't really matter as it still happens." (Indian ethnicity)

"So Black people died to begin with because they were on the front line and were unprotected. The NHS that, they dedicated their lives to and trusted, failed them." (Black Caribbean ethnicity)

Views and experiences shared across all forms of engagement provide a detailed insight into why many Black and Asian people do not trust and lack confidence in the NHS. This paper will these in-depth, focusing on lived experience and cultural competency within healthcare services.

Lived Experience: Discrimination

45% of survey respondents felt that they had been discriminated against in a healthcare setting. Many respondents believed that they experienced discrimination because of their ethnicity, and that a White person would not have been treated in the same way. Similar views were reported during one-to-one interviews and focus group discussions.

"I have a biblical name so people assume I am white, and when they see me I am presented with implicit bias, negative body language and microaggressions because I am not white." (Black Caribbean and White ethnicity)

"It's hard to explain but it was how they spoke to me. It's how they dismissed me and made me feel like I'm a burden. And it definitely felt like it's because I'm a Black woman. They didn't have time for me and were rude and discriminatory." (Black African ethnicity)

"I've had nurses and doctors speak to me differently as [they] might not be able to understand what I was saying even though I'm British they just make racist assumptions." (Indian ethnicity)

"And sometimes it's like prejudice I guess? If you wear a headscarf, if you appear a certain way, people assume you're not educated or they can't speak the language, and your healthcare is affected. Once they start talking to you and then they realise oh OK this person can speak and is assertive then they will change their tone. They will speak to you in a different manner." (British Bangladeshi ethnicity)

Racial Stereotypes

Some respondents felt that discrimination in healthcare stemmed from stereotypes associated with their culture or ethnicity.

A number of Black respondents discussed the false stereotype that Black women are physically and mentally stronger than White women, and have a higher pain tolerance and threshold. Respondents said they are often refused medication, not believed when they say they are in pain, and not listened to or taken seriously by healthcare professionals because of this stereotype. For example, one respondent shared how clinicians performed a procedure on her foot without providing pain relief. The respondent was screaming in pain, resulting in one nurse having to intervene and tell them to stop the procedure.

"They definitely thought, or at least the older, senior nurse thought, she's a big Black women, she's fine, being dramatic, whatever." (Black Caribbean ethnicity)

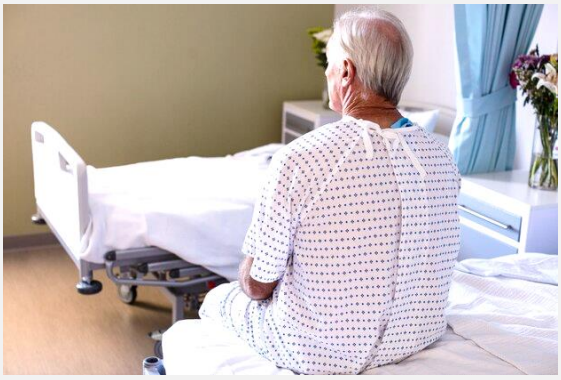
In some instances, respondents shared the healthcare experiences of their friends and family when providing examples of discrimination. This again demonstrates the complexity of attitudes in that some Black and Asian people don't necessarily have negative experiences of their own, and instead the experiences of their family, friends and other community members can influence their perceptions on the NHS. For example, one respondent talked about how her friend was not offered painkillers until she was very far along in her labour. The respondent felt they had not offered her painkillers due to the stereotype that Black women are stronger, which left her in a lot of unnecessary pain and made the labour experience even more difficult, both physically and emotionally.

"Black women are perceived to have a higher pain threshold. Even though this is not true. This comes across." (Black Caribbean and White ethnicity)

"If you are Black it's hard to get the treatment you need especially as we are perceived as strong and cannot have mental health. We are told we come from the most suffering continent and are more strong to have mental health." (Black African ethnicity)

Personal Stories: Racial Stereotypes

*Please note that within the personal stories, the names of respondents have been changed to protect their identity.



Lei*, a Chinese respondent, talked about the impact of the racial stereotype that Chinese people are quiet and will not challenge staff if they receive unfair treatment: *"I feel there is a perception by some staff that Chinese people will not complain, answer back or cause an argument. This is true culturally, so then these staff will put the Chinese person last, belittle them or not listen to them."*

Lei shared a story about her father's experience of being in hospital, and not being cared for properly, which she believes was due to staff disregarding his needs due to their perceptions that Chinese people will not complain:

"Most staff encountered are good, but in hospitals mine and my family's experience is that we are sometimes ignored or spoken down to. I feel this treatment is a perception that Chinese people are reticent and not loud, assertive people. For example, my dad desperately needed his bladder emptied via a catheter. He kept asking politely but was ignored for hours, and was told he didn't need it. He was in pain. When it was finally emptied by another shift (and we had arrived in hospital and could ask for him), the new nurse said she was sorry because she realised he must have been in pain due to the volume emptied. A fellow patient in another bed (White) said to me afterwards "Your dad is such a softly spoken, polite man, he has been asking for hours for help but they kept fobbing him off. I could tell he was so uncomfortable, but he didn't complain and kept on being polite." I think this is where Chinese people may not be treated in the same way as White people."

Asian respondents also shared how stereotypes associated with their race or culture impacted their treatment. Caring for elderly relatives is an integral part of many Asian cultures, however, a number of Asian respondents discussed how this places a burden on families and can be particularly challenging when there are competing priorities, such as work and childcare. Respondents felt that healthcare professionals often expect Asian people to care for their relatives and take the responsibility away from services. Respondents

said that services provide very little help, meaning they feel alone and unsupported in caring for their relatives.

> *"In the Asian community we look after our elders. The services think there is no need to support them because they're being looked after within the family… To look after someone on top of that is a big, big strain. It's a big ask."* (British Bangladeshi ethnicity)

> *"Frequently there appears to be an expectation and assumption that I will be supported by my family and/or extended family rather than assistance provided by the NHS."* (Indian ethnicity)

> *"There's extended family members and it's almost like a relief to services, as in they think there's an expectation that things will be picked up, and therefore we don't need to worry…"* (Indian ethnicity)

> *"There's an expectation that Indian extended family structure will/should be able to cope with care of elderly and dementia related needs."* (Indian ethnicity)

These examples of racial stereotypes demonstrate how Black and Asian people may be cared for differently than their White counterparts due to stereotypes associated with their race or culture. This can decrease the standard of care they receive and leads to poor experiences, highlighting the importance of healthcare professionals listening to and meeting the needs of all patients.

Poor Experiences in Maternity

A number of Black and Asian women shared having poor experiences with maternity services. Respondents said they weren't listened to when in pain, their wishes around their birth weren't respected, and they weren't checked properly following birth which in some cases, led to serious complications. For some Black and Asian women, their experience had positive and negative aspects, and it often depended on staff members and the care they provided.

> *"My actual midwives were amazing, I would not have wished for anyone else to greet my children into the world. However, the care before and after was appalling…Whilst in pain, the doctor assessed me and said there was no way I was in labour because he could not feel any afro hair and he has never seen a Black baby without any hair. I gave birth to my bald baby 3-4 hours later. Being left in pain because I was not screaming, but kept saying I'm in pain, but my words were not being heard. Maybe because I was expected to be a strong Black woman."* (Black Caribbean ethnicity)

> *"I had to stay in hospital for three weeks after the birth. My experience here was extremely variable from midwives who berated me for coming back to hospital (I had septicaemia), saw patients as objects and didn't listen to my history, to others who really tried their best for their patients."* (Chinese ethnicity)

Personal Stories: Maternity Services

Janelle*, a Black Caribbean and White respondent, shared her experience of maternity and how the physical and emotional trauma had a long-lasting effect.

"The worst of my experiences has been through maternity services where I had complications with both pregnancies and poor care following both births in different hospitals 7 years apart. In both cases I had to stay on the wards for several days, so this compounded the situation. I developed Symphysis Pubis Dysfunction in both pregnancies, but was not believed in the first, meaning that I was not supported in giving birth and had a partial hip dislocation, my baby could not fully turn on delivery and so I had a third degree tear."

"The traumatic experience left me with post-natal depression, and a lack of care from midwifery during and after the birth. I was told that I could not walk because of the tightness of my stitches even though I told them I had great difficulties before the birth which were made worse by it. Even at the early antenatal stage, I alerted my GP and antenatal service in London and then in Herts when I moved home. Both health providing teams did not take me seriously and gave no treatment or consideration. It was only when I saw the physiotherapist in hospital after begging for 2 days for help, that she came and tested my reflexes, acknowledged the significant issues and got me access to appropriate support. I was so mentally affected by the trauma of the first pregnancy that I had to wait several years before I could muster the confidence to go through the health system again to have another child. "

Personal Stories: Maternity Services

Steph*, a Black Caribbean respondent, talked about her negative experience of labour and birth. When arriving in hospital and shown to her room, Steph was left on her own without support.

"They left me in a room for four hours on my own. When I clearly needed help. And the midwife that was there sat there, just reading a magazine the whole time."

When it was time to deliver her baby, Steph told midwives that she felt more comfortable to lean on her left side. However, a midwife told her she needed to give birth on her right as Black women's wombs are shaped differently and so it's better to give birth on the right. Not only is this incorrect, but Steph's wishes weren't listened to.

"She wanted me to turn on the right to give birth when I felt more comfortable on the left. And then she told me, she whispered in my ear some story about how 'I know Black women…' I'm like lady I don't want to hear this now!"

After giving birth, healthcare professionals left part of the placenta in Steph's womb, which can be life-threatening. Steph said she didn't realise that this was so serious until she was talking with family two years later.

"A midwife did come to house and she said there was a piece of afterbirth. But she didn't tell me that it could have killed me and how dangerous it was. There was no follow up call of apology, there was nothing."

Steph talked about how she began to realise this was a problem that particularly impacts Black women when she attended support groups and heard other Black women share similar stories.

"This one group I was going into, we were sharing stories, and about four other women shared the same story as me, the afterbirth being left in them. And that's how I found…I think there's a problem here."

The above personal stories contain particularly concerning experiences with serious consequences for both physical and mental health. Currently, there is no national evidence that shows that such experiences disproportionately impact Black women. However, there are risk factors and other influences that offer insight into these experiences.

To consider Steph's story, a retained placenta is a rare condition, but some potential risk factors have been identified. One such risk factor is fibroids, which are more common in Black women than White women. It is important that healthcare professionals understand conditions and risk factors that primarily impact Black women so they are able to better support Black women through pregnancy and labour.

It's also important to recognise that lived experience, either inside or outside of the healthcare system, can impact people's perceptions of a poor experience, and whether they feel their treatment was racially motivated. For example, it has been highlighted that some professionals may, whether consciously or sub-consciously, believe that Black women can tolerate pain better than their White counterparts. For Black women who have poor experiences in maternity, this may also contribute to their belief that they did not have their pain believed on the basis of discrimination. This context is crucial for understanding how a culmination of factors contribute to a mistrust in maternity services.

Treatment from Reception and Administration Staff

Respondents discussed their interactions with healthcare professionals, and how some treat them with more respect than others. For example, many respondents reported poor experiences with reception and administration staff. In particular, reception staff were seen as discriminatory and as 'gatekeepers' who acted as a barrier to healthcare services.

Concerns with receptionists and administration staff are common across the general population. However, Black and Asian respondents tended to feel that their treatment was discriminatory, rather than being the result of widespread issues. As has been discussed repeatedly throughout this report, it is again worth remembering that respondent's day-to-day experiences, and their knowledge of systemic inequality, are both likely to heighten perceptions of discrimination. This highlights that not only is there a need for improvement within administration sectors of the NHS, but that trust-building broadly is essential so that Black and Asian respondents don't have the expectation that they will be discriminated against in a healthcare setting, which in itself is an access barrier.

> *"The receptionists are gatekeepers and want me to describe my symptoms."* (Black Caribbean ethnicity)

> *"Since pandemic, there has been a lack of tolerance from front desk staff and rude with their approach, and not making an effort to be able to pronounce easy Asian names."* (Bangladeshi ethnicity)

> *"I usually just find receptionists at GPs rude. I don't know if that's just my experience but they always seem to be rude…I don't know if that, what I might see as an age thing, could be a race thing. I don't know. But there is often the feeling of we're not on a level playing field."* (Black ethnicity)

> *"The administration or the receptionists can be pretty bad. They do put the White people forward and then the Black person or the brown person at the back. The brown person especially is always at the back of the queue."* (British Pakistani

Encounters that patient have with reception and administration staff are particularly important as these are often someone's first point of contact upon entering a healthcare setting. If someone has a poor experience and feels discriminated against, this can immediately reinforce their view that the NHS is not built for Black and Asian people.

Culturally Competent Care

Respondents talked about cultural competency[11] within services, or lack thereof, and how it impacted their care. Typically, respondents felt that services are not designed to deliver culturally competent care. In some instances, respondents told us that the NHS is not there to care for Black and Asian people.

> *"I think the NHS is like any system. It serves its purpose. And it's doing what it's supposed to be doing. It's just not there for us. It's not supposed to be there for us as Black people. I think people say the system is broken. It's not really how it's supposed to go. It's just that it's really not in our favour. And never has been."* (Black ethnicity)

This is similar to findings discussed earlier in the report which demonstrated that almost half of our respondents feel that a White person's health is better protected by the NHS than their own. For some people, their perception of the NHS not providing proper care for Black and Asian people means they try to avoid accessing healthcare.

> *"It has become more evident that bias exists and research has shown the damage it causes – I try and stay away to protect my mental and physical health."* (Black African and White ethnicity)

> *"My last experience was so poor I refuse to go back for myself."* (Black Caribbean ethnicity)

Other specific themes were raised by respondents, relating to a wide range of instances in which culturally competent care was not provided, highlighting opportunities for improvement. This is discussed in the following sections.

Training and understanding of health in Black and Asian populations

A number of respondents discussed how healthcare professionals didn't always have an adequate understanding of conditions that primarily affect Black and Asian people, or understand how conditions may present on darker complexions. For some respondents, this led to delayed or incorrect diagnoses, and for others, they were denied prescriptions they needed. It also meant that some respondents felt they weren't given enough information to be able to understand or manage their condition. For example, a Black

[11] Cultural competency is the ability to effectively interact with people belonging to different cultures.

respondent shared a time when her children were ill with scarlet fever. Clinicians misdiagnosed this as heat rash, as they could not make out the bright red rashes on darker skin, despite them having other symptoms of scarlet fever.

> *"There doesn't seem to be enough clinicians with knowledge of how conditions and diseases manifest and affect Asian patients."* (Indian ethnicity)

> *"I have felt that the health conditions I have expressed to the white clinicians have been ignored based on their lack of understanding of Black skin."* (Black African ethnicity)

> *"Service providers are not trained in issues related to issues specific to non white community. It's isolating and creates issues of trust."* (Black African and White ethnicity)

> *"Some of the health issues I have faced are not treated under the NHS and I believe that it is because something that predominantly people of colour face."* (Sri Lankan ethnicity)

> *"With my acne, because I've got darker skin, the scarring is a problem. So, even if the acne heals, the residual scarring…I don't think I got enough information about what that would mean for me and how long it would take to go."* (Indian ethnicity)

One respondent shared her friend's experience of fibroids, a condition which particularly impact Black women. She felt that clinicians lack an understanding of fibroids and that this, coupled with racial stereotypes about pain tolerance, resulted in poor care.

> *"I think they were just like oh she can endure it…because she's Black and supposed to be stronger, they were like you can just live with it…I think they would have given to maybe a white woman if she was experiencing something similar. But I think it's not as common with white women so it's not taken as seriously."* (Black ethnicity)

Respondents felt that staff needed better training on being able to recognise and treat conditions that primarily impact Black and Asian people.

> *"There needs to be more research into how diseases and conditions affect Asians and the clinical staff need to update their knowledge to be better able to support Asian patients."* (Indian ethnicity)

> *"Better awareness of conditions that affect ethnic groups."* (Indian ethnicity)

> *"Take the time to check if there is any different guidance that needs to be followed for the BAME community."* (Black Caribbean ethnicity)

"I feel that the non BAME consultants/clinicians could be more culturally aware and to not have prejudices of other health conditions and situations." *(Black African ethnicity)*

"Address medical education for all doctors." (Black African ethnicity)

Respondents felt that clinicians don't understand physical and mental illness in Black and Asian populations. They felt that a lack of cultural awareness and understanding means that healthcare professionals cannot understand the causes of their ill mental health, and could not provide support that accommodated for their culture. For example, stigma associated with mental health meant it was difficult for some respondents to make changes to their lifestyle that their therapist felt would benefit their mental state.

"Therapists all white – do not understand issues for people of colour." (Black African and White ethnicity)

"It's getting better but we don't expect white people to know anything." (Bangladeshi ethnicity)

"They don't understand anything about me and they don't try to understanding. They don't ask about my culture, my background." (British Pakistani ethnicity)

"I guess when it comes to Asian communities, and I guess BAME communities in general, services, especially mental health, need to be open minded about faith, culture, family background. It is a sensitive issue but it's part of people's identity." *(British Asian ethnicity)*

Personal Stories: Mental Health

Yasmin*, a British Asian respondent, shared her story of using mental health services. She discussed her experience of receiving Cognitive Behavioural Therapy (CBT) from the NHS when she was struggling with ill mental health and relationship problems.

Despite living with ill mental health for some time, Yasmin didn't know what help was available or how to access support for her mental health.

"I found it very hard to access services at first, I didn't know they exist. I didn't know they were available. I didn't know anything or how to access anything. I didn't know where to go."

Yasmin said that there is a stigma attached to mental health within her community, meaning she couldn't speak to her family and friends. This made it more difficult for her to find support.

Although she was treated with dignity and respect by the therapist, Yasmin felt that she didn't receive the care she needed or deserved due to the therapist not understanding how culture impacted her health and how she could manage it.

"At the time I was living with extended family and that's fairly common in Asian culture to do that. It's easy enough for someone to say if you don't get on, if they don't like you, whatever reason, then just get out of it. But when you live in an Asian family you can't just get out like that, it's not easy and that's the problem."

Yasmin also spoke about how the therapist didn't understand that leaving a relationship was frowned upon by people close to her.

"And if you leave your husband, then there is a stigma attached to it… [the therapist] would say just leave. Just go. But it's not that easy, is it? It's not easy if you're not part of that culture. But when that is your culture, it's impossible."

Yasmin felt that an Asian therapist would have been more understanding than a White therapist, and would have been able to support her better.

"I think if they had Asian therapists, people who could understand the intricacies of Asian culture and things that are specific to us and our community, that would really help people."

Respondents felt that Black and Asian healthcare professionals were aware and more sensitive to their culture, and that they took the time to listen to them. Respondents felt more heard and tended to receive better care from non-White healthcare professionals, and wanted to see more Black and Asian staff in the NHS workforce as a result.

"My GP is Black. He shows a high degree of empathy and knowledge of my health and my health in relation to my ethnicity." (Indian ethnicity)

"Asian GP are good and understanding." (Bangladeshi ethnicity)

"When staff are BAME they tend to be better." (Indian ethnicity)

"Have more staff from an ethnic background – Black African is completely different to Black Caribbean." (Black Caribbean ethnicity)

"Employ more Black doctors and healthcare workers." (Black African ethnicity)

"More Black people in senior positions that hold authority to implement change." (Black Caribbean ethnicity)

Dietary preferences and requirements

A number of respondents shared how their dietary preferences and/or requirements were not met when using NHS services. For example, respondents told us that they weren't asked if they have dietary requirements, such as an Halal diet, and that menus mostly accommodated for Western diets.

"There was nothing asked about cultural needs, do you have a Halal diet? They were just so busy." (British Bangladeshi ethnicity)

"They didn't always make sure they had the right food available that met my cultural and religious needs." (British Pakistani ethnicity)

"They've got to understand that I can't change something that mum has been eating for so many years and suddenly I'm being told "Oh you can't give her this."…What about changing your diet plan to accommodate the patient?" (British Pakistani ethnicity)

One respondent who has diabetes talked about how important her diet was, not only for cultural reasons, but also to ensure that her blood glucose levels stayed within range. The respondent was an inpatient in hospital for two months, and said that at no point did they accommodate for her requirements.

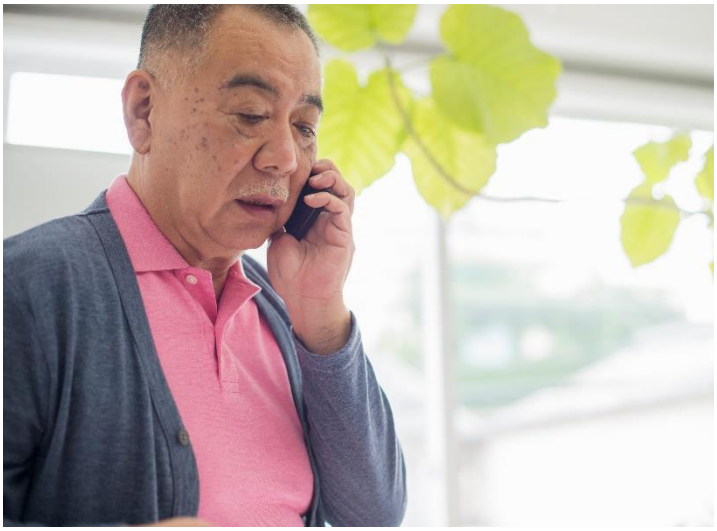
"I was in hospital from 26th August up until November and I never got a Caribbean menu…I'm diabetic and my meals are balanced…It meant my daughter had to cook my meals and bring my meals in. I was frightened that if my blood sugars aren't right I won't get better and the cut on my foot won't heal." (Black Caribbean ethnicity)

Another respondent with diabetes shared how her diabetic nurse tried to be accommodating of her diet, but that the nurse used microaggressions and behaved awkwardly, making this a poor and uncomfortable experience for the respondent.

> *"The one she recommended me was world foods or something. And I get what she was doing. But she was so awkward about it. And that's what the problem was. I think what she was doing was nice but it was like she didn't want to talk about it or address it? She didn't want to have the conversation. And I think we need to have open conversations about culture and things like that… She would use words like 'people like you', 'you people', it made me feel like I don't know… like I'm not normal?"* (British Asian ethnicity)

Language barriers

Respondents told us that language barriers can prevent patients from receiving the care they need, or mean that they are treated disrespectfully by healthcare professionals. Some respondents said that their experience had been fine because they speak English, but expressed concerns for those who don't speak strong English.



> *"I think sometimes if they're on the phone there can be a bit of a language barrier or it could be that they can't hear or understand what the other person is saying on the other end."* (Black ethnicity)

> *"She doesn't speak a word of English. No one was allowed to stay overnight with her, so then it was very hard for her to communicate."* (British Bangladeshi ethnicity)

> *"Overall my experience has been positive, but that is because I do not have an accent and can articulate intellectually if unhappy about treatment. My mother was admitted as an emergency patient following a non-covid problem, which [was] serious. Due to her inability to converse fluently she was left distressed, crying in pain and refused all her autoimmune medication. The nurses had no comprehension of the importance of her meds. She has full capacity but because of language barriers was treated as incompetent!"* (Indian ethnicity)

Personal Stories: Importance of Language Support

Aashvi*, a British Indian respondent, shared how her mother-in-law needed tests done at the hospital at a time when COVID-19 restrictions were in place. Due to English being her mother in law's second language, Aashvi needed to accompany her to provide language support. However, the nurse carrying out the tests didn't feel it was necessary for Aashvi to attend.

"She clearly didn't like the fact I was going to have to go in with mum. She looked uneasy. Hesitated…her manner became quite off from the beginning."

"She clearly didn't see a patient who needed support from a additional member, that could have been a carer, could have been a family member, but clearly that person needed that."

The nurse told Aashvi and her mother-in-law the tests she was going to carry out, and it included an internal test that they had not been previously told about. Aashvi questioned this with the nurse, who realised that she had read the notes incorrectly and that was the wrong test.

Aashvi was very concerned that had she not been present, the nurse would have performed invasive tests that her mother-in-law had not needed, as her mother-in-law would have been unable to communicate to understanding what was happening.

"If I wasn't in the room, she wouldn't have known. If I hadn't said I'm here to support her, if I had stayed in reception and hadn't gone in, she would have ended up doing more than likely those tests, which would have caused mum-in-law quite a lot of stress."

"I'm also mindful that it's all about communication as well and that shouldn't be a barrier. And it was all about communication that went wrong there. And it was quite a distressing situation."

However, some respondents felt that language was not always a barrier. When patients were spoken to in their own language, people were grateful for this. This offers an example of good practice that should be learnt from.

> *"Obviously with her dementia she is losing a lot of her ability to communicate well but some of the nurses who speak Urdu or Punjabi, they spoke to her in her language and she was really pleased."* (British Pakistani ethnicity)

Other respondents, despite not needing language support themselves, felt that resources in different languages were easily available and that often, patients could find a staff member who could speak to them in their preferred language. However, it is important to note that simply having staff members who can speak different languages does not suffice as adequate language provision. Language and translation support should be readily available and healthcare professionals should not have to search for other clinicians to provide this support. It is also not the patient's responsibility to seek language support, and they should have all the necessary resources available to them to be able to use healthcare services with confidence. By

having language support available, everybody can benefit; it makes the patient's experience positive and helps the healthcare professional to better assess their patient's needs.

> *"Maybe actually, pick up the phone to a language line, because it's there. Actually use it, rather than you know, seeing it as another thing to do…if they understand fully the first time, then that's in the interest of the professional as well, to make their life easier."* (British Indian ethnicity)

It should be noted that often, respondents who discussed language provision did not themselves require language support, meaning their views may not be representative of groups who do require support.

Religion

Some respondents discussed the importance of being able to practice their faith whilst using NHS services, and how this wasn't always accommodated for. This is not to say that NHS institutions do not provide these services, but that they aren't always well known and it can take work on behalf of the patient/their family to find this support. For example, one respondent only knew about being able to organise a Muslim clergy to visit their mother due to personal contacts.

> *"…there is a service at [hospital] to have a Muslim clergy. This was never highlighted by the hospital, I only knew through my personal contact."* (British Pakistani ethnicity)

Another respondent asked for a priest multiple times, and this was not accommodated.

> *"…and so I didn't get to see anyone, they didn't find me anyone else even though I asked many times. I found that affected me. I needed to see someone."* (Black Caribbean ethnicity)

When using healthcare, particularly during inpatient stays, faith often brings a sense of peace and comfort to people, and the value of this cannot be understated. Not making these services easily accessible can be detrimental to the wellbeing of patients and can make an already challenging time even more difficult.

Cultural practices, preferences and requirements

Similar to religion, cultural practices, preferences and requirements hold great meaning and value for many people within Black and Asian communities. Respondents told us that NHS services did not listen to what was important to them and did not always accommodate for their cultural needs, and that this impacted their experiences of care.

> *"I did explain that mum and I would rather have a woman carer coming in. Let me just give you an example, out of 10 times, 7 times they sent a male…in the end I stopped the service after 2 weeks and I phoned up the social worker and said I wanted the care stopped. I feel this is really important and it is something I really hope your survey can change as it was awful."* (British Pakistani ethnicity)

"She said to me "I'm going to order you a kitchen stool and you can put the stool at the sink and you can have a wash."...in our culture the kitchen sink is a no go! None of that happens!...The woman said "What's the problem? I thought I was helping you."...But she didn't care, she didn't think she did anything wrong." (Black Caribbean ethnicity)

There may be instances where a healthcare professional is unaware of a particular cultural value or practice. This does not have to be viewed negatively, but there are things to consider to make sure that this doesn't negatively impact a patient's care. For example, cultural competency training and focusing on providing person-centred care, which could include taking 5 minutes to speak to a patient about their cultural values and preferences, could make a patient's experience a positive one. Importance lies in demonstrating that a patient's voice has been heard and that services are working to accommodate for their cultural practices and values for the duration of their care.

For services to know how care is being received in Black and Asian communities, they need to hear feedback from a diverse range of patients. One respondent expressed concern regarding a lack of checks on community care within their Sikh community. The respondent questioned how services could be culturally competent without understanding the issues.

"From personal experience, I know that within the community there's a lack of the kind of spot checks that are done by Herts County Council, when they check on packages of care...they have somebody who actually contacts individuals to see how they're finding the package of care. In the community we haven't found one person who has English as their second language, in the Sikh community that is, who will say they have received a call asking for feedback about package of care...but if you're not hearing from the community, are you actually spending time to find out why, and whether you could engage with that community and find out how you could do things differently?" (British Indian ethnicity)

These experiences demonstrate that services are not always designed with Black and Asian people in mind. In order to develop person-centred care, services need to ensure they cater for everybody's needs and preferences, so people feel comfortable and valued when using NHS services. Many respondents suggested cultural competency training as an area for improvement for all NHS services.

"Be more aware of cultural differences. Respect for patients wearing turbans or hijabs when conducting procedures. Make sure they are made comfortable if removal of articles of faith are required." (Indian ethnicity)

"Train receptionists and administrators about cultural sensitivities and how to respond to Asian patients." (Pakistani ethnicity)

"Cultural training for ALL staff." (Black Caribbean ethnicity)

"There needs to be more training and awareness. It's really important to incorporate that…just because we dress differently, still have our culture, still have our religion that we follow, that shouldn't discriminate us." (British Pakistani ethnicity)

"These people need more training. What a disaster. They need to learn about different cultures. It doesn't need to be difficult, doesn't need to be hard. And they can get it wrong but address it and have some respect. Stop making me feel like I'm asking for too much. Stop making me feel bad when I ask for the Caribbean menu, or ask if I can be washed. I feel like I'm the problem as a Black woman but I'm not." (Black Caribbean ethnicity)

However, there were some cases in which cultural values were respected and healthcare professionals went out of their way to provide person-centred care. For example, one respondent shared how staff cared for her hair whilst in intensive care, which meant a great deal to her and her family, and showed that she was being well looked after and her culture respected.

"In our culture it's really important that you are put together. Like the washing I told you about. My daughter said I don't know who was doing your hair in Intensive Care but I know you didn't do it as you weren't even awake. But they did my hair, put it in bunches one day, another style the next. But it really moved her. It was really important and they did that." (Black Caribbean ethnicity)

Not feeling heard

When discussing their views and experiences of healthcare, many respondents said that they did not feel heard or listened to by healthcare professionals. This feeling was noted in many different circumstances, whether that was dietary requirements not being met, preferences for a female care giver not being accommodated, or symptoms not being listened to and taken seriously. For example, one respondent shared that she tried to tell clinicians that she had previously had a bad reaction to morphine before undergoing a procedure. Her concerns were not listened to, and clinicians continued to administer morphine, causing the respondent to badly vomit. For people who may already be hesitant about accessing healthcare and have a lack of trust in the NHS, not feeling heard acts as a huge barrier for building trust.

"Because when I share things that are specific to me based on my ethnicity, I don't feel that I am heard or that they are taken into consideration." (Indian ethnicity)

"I felt completely ignored and powerless. It was frustrating as a person who feels she has a voice. I also felt very let down." (Black Caribbean ethnicity)

"I have been treated differently – usually not taken seriously or have my views minimised which has caused me to suffer further health complications when accessing services." (Black Caribbean and White ethnicity)

"Being Asian, I feel I have to speak louder to be heard. Almost as if our health has no significant or is of importance." (Indian ethnicity)

"I have been made to feel like I'm over exaggerating my needs or had them almost ignored by professionals. I've hard to argue with them to gain access to support." (Black Caribbean ethnicity)

"Consultant only conducted a very superficial assessment without actually listening to my concerns or investigated any underlying issues." (Indian ethnicity)

"There are lots of things specific to Asian communities and they don't get that or try to understand. They just nod and move on and tell me I don't need their support anymore. It's awful." (British Pakistani ethnicity)

One respondent made it very clear to the clinician that her son did not require a specific vaccination due to not being in contact with anyone abroad, but this was not listened to and resulted in this respondent's wishes being disregarded.

"Even when I explained to the health professional that asked about vaccinations when I had my first son, I was clear that I did not have any contact with people from abroad, but was made to give my baby the BCG vaccination as protocol because I am not White. That's not okay." (Black Caribbean and White ethnicity)

It is also important to note that the provision of informed consent, from either the patient or a person acting on their behalf, is essential in healthcare. Examples such as the above demonstrate that there are instances in which consent has not been correctly obtained. The repercussions of not gaining consent can be far-reaching and professionals must have informed consent prior to performing any procedure.

Due to not feeling heard, and that their care needs are not met, a number of Black and Asian respondents talked about the need to advocate for themselves, and speak assertively with healthcare professionals, to get the care they need. People felt it was unfair that Black and Asian people have to be vocal to receive the same level of care as a White person.

"I do feel like I'm not listened to though, I feel like I have to work four times harder. People from ethnic backgrounds do tend to have to work four times harder to get heard. As a brown person or a Pakistani I have to work four times harder." (British Pakistani ethnicity)

"It should be fair for everybody. Why should you have to be so assertive? Why should you push? It's draining. The services are there to meet your needs. It shouldn't be whoever shouts the loudest gets heard. It shouldn't be that way." (British Bangladeshi ethnicity)

> *"As a Black person I've had health issues for years. And sometimes I think if I wasn't a person, naturally in the jobs I work in I advocate for people, if I wasn't one of those people that knew I've got to stand up for myself, then I would have gotten nowhere."* (Black ethnicity)

Respondents also talked about the need to advocate on behalf of others, often family members, who were unable to advocate for themselves. This is similar to concerns people had around language barriers; though they themselves may communicate confidently in a healthcare setting, they were concerned for those people who would not.

> *"I was thinking that in my mum's case I had to speak up for her, what if someone can't speak up for themselves? What happens to those poor people?"* (British Pakistani ethnicity)

> *"I'm intelligent enough to say actually no, hold on a moment, remember the reason you took Mum and Dad off that medication is because of that…if you've got somebody who can't say hold on a moment, they'll end up having the wrong medication…We have to complain on their behalf because they're not used to complaining…there is a generation gap and as I said, we will stick up for ourselves because we know we have the right to stick up for ourselves. These guys, as I said, they're old school, they won't say anything."* (Black ethnicity)

Summary

Our engagement with Black and Asian communities shows that there is a mistrust towards the NHS, often due to personal poor experiences or the experiences of others, as well as the existence of ethnic health inequalities more broadly.

Many respondents discussed feeling discriminated against, whether this be directly when experiencing poor treatment from administration staff, or indirectly when they feel their care has been impacted by racial stereotypes. As has been reiterated throughout this report, it is not whether a healthcare professional intended to be discriminatory that is important, but how the patient felt. It is the patient's perception of their experience, that can contribute to mistrust and a lack of future engagement with the healthcare system, which can ultimately have implications for somebody's health in the long-term.

In some instances, there were severe physical and/or mental consequences associated with people's poor experiences. These were particularly prevalent in stories shared around maternity services. Given national statistics on mother and infant mortality in Black populations, particular attention must be paid to maternity experiences to ensure that Hertfordshire's maternity services provide safe care for mothers and babies of all ethnicities.

Respondents also shared how a lack of cultural competence meant that their needs, preferences and requirements were not always met, whether this be a dietary preference or the need for a female rather than a male caregiver. Though the consequences of these experiences are less likely to have a severe medical

impact, they can still contribute to the feeling that the healthcare system is not designed with Black and Asian people, leading to a reluctance to engage with services.

The impact of these experiences on people's trust in the NHS strengthens the need to provide personalised care for everybody, which must include Black and Asian communities by addressing their ethnicity, culture, race and religion. It is also essential that NHS services engage with Black and Asian people in a way that makes them feel valued; by listening to their needs and treating all patients with dignity and respect. It is only through learning from pervious mistakes, and working with communities to put right the wrongs, that the system can effectively tackle ethnic health inequalities.

Key findings: What the NHS told us

Introduction

At the time of interview, Clinical Commissioning Groups (CCGs) were still in place across Hertfordshire. As of July 1st 2022, the Hertfordshire and West Essex Integrated Care System (ICS) came into force, dissolving and replacing three CCGs (Hertfordshire Valleys CCG, East and North Hertfordshire CCG and West Essex CCG). The ICS brings together partners from all sectors, including the NHS, local authority and community and voluntary groups, to provide better, more integrated care to patients.

Within Hertfordshire, there are three Health and Care Partnerships (HCPs) that sit under the ICS (East and North Herts, South West Herts, and the Mental Health, Learning Disability and Autism Collaborative). These partnerships bring together partners from all sectors within specific local areas to deliver placed-based care.

Please visit the King's Fund webpage for more information on how Integrated Care Systems work.

We interviewed senior staff from the two CCGs in Hertfordshire. The findings reflect what they told us, as well as what providers shared. The findings do not reflect the policies and procedures of the ICS as this was not formally established at the time of engagement. However, the findings and recommendations have broad relevance and must be taken forward by all healthcare bodies, including the ICS, as we move into a new chapter of integrated care.

Although there is a clear commitment from the NHS to tackling ethnic health inequalities, with many initiatives and interventions in place with the intention of reducing disparities, our engagement with the NHS and Black and Asian people identifies that more needs to be done if services are to improve the experiences and health outcomes of Black and Asian communities. Areas for improvement and examples of good practice are outlined in the findings below.

Governance

Policies and strategies

None of the Trusts have, or CCGs at the time had, policies or strategies in place that specifically address or refer to Black and Asian communities. Although they all have a range of equality, diversity and inclusion policies in place, these tend to focus on all protected characteristic groups under the Equality Act (2010), and do not look at race or ethnicity exclusively. Where ethnicity is specifically addressed within policies, all ethnic communities are grouped under "BAME".

By homogenising all non-White people into the same category, services cannot adequately meet or understand the specific needs of Black and Asian people or indeed any ethnicity. This has a direct effect on their ability to provide culturally competent and personalised care, as well as their ability to effectively address the wider issue of ethnic health inequalities.

Equality Impact Assessments

Ensuring that Equality Impact Assessments[12] (EIA) are completed consistently and thoroughly was identified by all Trusts and both CCGs as an area for improvement. They noted that staff tend to view EIAs as a "tick box exercise", largely because the template lends itself to be approached in this way. Other barriers include a poor understanding amongst staff about the importance of completing EIAs, and staff not having the time or capacity to complete EIAs comprehensively.

Providers and commissioners plan to provide greater support and training to ensure staff are detailing in-depth how they have considered and/or engaged with protected groups, and how they will ensure communities are not disadvantaged by service changes.

Cultural Competence

Equality, Diversity and Inclusion Training

Equality, diversity and inclusion training is mandatory for all staff in the NHS. Providers and commissioners should report and monitor compliance, however some could not provide figures for the uptake of this training amongst their staff.

Some Trusts offer additional training programmes, including training on cultural competency, anti-racism, unconscious bias, and understanding health inequalities. The CCGs that were in place at the time also offered such programmes. However, these training programmes are only offered to frontline staff, of which the uptake tends to be low, particularly amongst staff in lower bands.

All staff, including staff that are not frontline, should be offered additional training. This is particularly important as our findings highlighted that many respondents had poor experiences when engaging with reception and administration staff in particular, noting incidences of mistreatment and in some cases, discrimination.

Respondents also noted the lack of cultural competency within services and how this negatively impacted their care. In response, respondents saw this as a key area for improvement and called for all staff to have cultural competency training. For example, training could focus on a better understanding of conditions that impact Black and Asian communities, and how conditions may present on darker complexions. Training could also focus on how healthcare professionals can meet the cultural needs and preferences of their patients, such as providing appropriate menus or making it accessible for people to practice their faith.

Translation and interpretation support

All Trusts provide translation and interpretation support for patients, should it be requested. However, not all Trusts record the language and communication preferences of patients, with the exception of Hertfordshire Community NHS Trust (HCT) which records this information on patient records – an example of good practice which other Trusts should take forward.

[12] Equality Impact Assessments are used to identify whether a new or existing service, policy, process or project might discriminate or disadvantage a particular group or community.

It is important that all Trusts record the language and communication needs of patients so the appropriate support can be provided if required. As found in our engagement, Trusts have been seen to rely on the patient or their loved ones to provide communication support which is not sufficient or appropriate.

Within Primary Care, CCGs carried out Quality Assurance Visits which focused on ensuring that the communication needs of patients were met, and that GP practices had the appropriate interpretation and translation support in place. This is an example of good practice which should be carried out by secondary care and community services.

Language and imagery

Providers and commissioners provide accessible communications by ensuring that people who have a disability, impairment or sensory loss get information they can access and understand. However, their communications are not culturally competent.

Using the right language is important in providing culturally competent communications. The term "BAME" is used as the default approach by all providers and commissioners when describing someone from a non-White ethnic group, which inappropriately homogenises ethnic communities into a single category. Their communications do not use language which reflects the specific ethnic group being referred to, for example the term "BAME" is used rather than "Pakistani". The language used in communications should be specific about ethnic groups where possible, and collective terminology should only be used when there is a legitimate need.

The same applies to the imagery used in communications. Providers and commissioners tend to use imagery that does not reflect the ethnic diversity of patients, or the specific ethnic group the communications apply to. Using the correct language and imagery is essential in helping Black and Asian communities feel represented, and in encouraging Black and Asian groups to access and engage with services.

Patient ethnicity data

Recording and collecting patient ethnicity data

Although all Trusts collect patient ethnicity data, some do not know what percentage of patient ethnicity data is recorded by their services, and most do not have a target in place for the recording and collection of this data. In terms of good practice, for admitted care, West Hertfordshire Teaching Hospitals NHS Trust (WHTH) recorded 96.3% of patient ethnicity data, compared to the national average of 85%. Additionally, Central London Community Healthcare NHS Trust (CLCH) has a completion rate of 91% across all of its divisions, in comparison to the national average of 61% across Community Services[13].

Trusts noted that collecting patient ethnicity data can be challenging, largely because patients do not always understand the relevance or importance of sharing this information, or because they fear disclosing their ethnicity will affect the care and treatment they receive. Staff can also feel hesitant to ask patients about their ethnicity as they have found this to be contentious for some patients. Implementing initiatives for reassuring both patients and staff is very important, as collecting ethnicity data plays a crucial role in improving service design and delivery, by helping services better understand and address disparities in health outcomes between different ethnic groups.

[13] Ethnicity coding in English health service datasets (nuffieldtrust.org.uk)

CLCH has introduced a number of successful initiatives for collecting patient ethnicity data. The Trust published various communication materials for staff, and delivered presentations to each division on the importance of recording ethnicity data, and its role in addressing health inequalities. To build staff confidence, the Trust created video and text guides, FAQ sheets, and scripts to support staff in asking patients about their ethnicity. The Trust also produced FAQ sheets and posters specifically for patients to explain why it is important for them to share their ethnicity data and how it will improve their care, and to reassure patients about how their data will be stored and used.

Sharing and reporting patient ethnicity data to commissioners

All Trusts are contractually required to share their equality, diversity and inclusion data, however the data shared with commissioners tends to merge all protected groups and does not look at ethnicity or Black and Asian people exclusively.

CCGs noted that the quality of ethnicity data collected by Trusts needs to be improved, and felt this was an area for the ICS to focus on. In some cases, the ethnicity data recorded is inadequate, including examples of incomplete coding, inconsistent use of codes, and ethnicity being recorded as "other", "not stated" or "unknown". Some Trusts will also record ethnicity as "Black Other" for example, when they could have been specific by selecting "Black African". This inadequacy and inconsistency in recording ethnicity data can prevent services from fully understanding ethnic health inequalities and the specific needs of different ethnic groups.

Moving forward, commissioners should specifically request ethnicity data from Trusts to not only ensure Trusts are held accountable for collecting patient ethnicity data, and also to ensure the data recorded is of high quality and consistent across providers.

Feedback and complaints

Linked to the above, although all Trusts, and CCGs in place at the time, told us they gather patient feedback and complaints, most (with the exception of CLCH and Hertfordshire Partnership University Foundation NHS Trust (HPFT)) do not record or ask for the patient's ethnicity when collecting this information. Asking for ethnicity data is particularly important when considering Black and Asian groups, as national literature has found that these communities are significantly less likely to feedback or complain about services. Often this is because they have concerns about the independence or impartiality of the process, or fear that providing feedback or making a complaint will negatively impact their care. This is reflected in our findings which highlighted how Black and Asian people often mistrust the NHS and fear they will be discriminated against or treated unfairly by healthcare professionals compared to their White counterparts.

Similarly, to collecting patient ethnicity data, collecting ethnicity data when patients share feedback or make a complaint is also important as it enables providers and commissioners to better address disparities, by being able to understand if there are themes within feedback from specific ethnic groups. This means providers and commissioners can identify learning which can be shared with services to improve them.

CLCH has introduced a number of initiatives for collecting feedback and complaints specifically from ethnically diverse groups. The Trust requests ethnicity data as part of its feedback and complaints process, and staff reassure patients that sharing feedback or making a complaint will not affect their care or be recorded on their patient records. Staff also actively encourage ethnically diverse communities to feedback, and highlight how making a complaint or sharing their experiences will help to improve services and the care

people receive. Feedback and complaints are reviewed every 6 weeks to identify where disparities might exist for specific ethnic groups, and to share learning and areas for improvement with their services.

Understanding ethnic health inequalities

Although Trusts and CCGs told us that they are very aware that Black and Asian people experience greater health inequalities compared to other ethnic groups, most were not clear on the types of disparities they are addressing for these communities, and could not provide specific examples of where health disparities for Black and Asian communities exist within their services.

Where Trusts and CCGs did give examples, these tended to be broad and looked at how services are addressing inequalities faced by a range of protected groups, rather than a specific focus on Black and Asian communities. Understanding health and care needs amongst different groups (otherwise known as Population Health Management[14]) was identified by all Trusts and CCGs as an area for improvement, with providers and commissioners recognising the important role Population Health Management plays in helping services to identify and address ethnic health inequalities.

The CCGs highlighted that within the ICS, there is a drive towards using Population Health Management to analyse health inequalities across the system, with a particular focus on ethnically diverse groups. Systems are in the process of being developed, with the ICS intending to use this data to improve health outcomes for ethnically diverse groups by supporting local services in designing and delivering new pathways and targeted interventions. Within population health management it will be crucial to complement this health data with cultural understanding for effective implementation and improved outcomes.

Maternity Services

Hospital Trusts and CCGs gave examples of how the Local Maternity and Neonatal System (LMNS) has been addressing ethnic health inequalities within maternity services, which has been commended at a national level. For example, in Watford, continuity of carer has been rolled out for ethnically diverse women, which involves ensuring they are cared for by a small group of midwives throughout their pregnancy, as this has been proven to significantly improve safety and outcomes. Other examples of good practice include producing tailored information and communication for ethnically diverse women, working with service users to create training videos for staff on cultural competency, and offering additional phone calls to ethnically diverse women to supplement their routine antenatal care.

These are positive steps forward and examples of good practice which other services can learn from, though there is still more work that needs to be done to improve the experiences of Black and Asian women in particular when accessing maternity services. As shown in our engagement, Black and Asian women shared experiences in which they were not given choice or involved in decisions around their pregnancy and labour, not listened to when in pain, and not given adequate postnatal care, leading to unnecessary complications and trauma, both emotionally and physically.

As highlighted in our findings, it is also important to note that even if Black and Asian people have not personally used maternity services, it often shapes their views on the NHS more generally, and is cited as an example by Black and Asian communities when explaining why they do not trust the NHS. Improvements in

[14] Population Health Management is a way of working to help services understand current health and care needs and predict what local people will need in the future. This means services can design and tailor better care and support for individuals.

maternity services will be essential for improving the severe disparities and outcomes of Black and Asian women, but also for building trust within these communities.

Representation, retention and recruitment

Building a representative and diverse workforce

Trusts and both CCGS told us that they have been improving the recruitment, representation and retention of ethnically diverse staff, and have been encouraging ethnically diverse groups to apply for roles, particularly in senior and executive positions. Though Trusts and both CCGs had seen an increase in diversity in lower bands in particular, they all noted that progress is slow, and more needs to be done, especially within higher bands and senior leadership positions.

National evidence shows that having a diverse and representative workforce can not only improve experiences for ethnically diverse staff, but can also improve access to care for ethnically diverse groups, and result in greater patient choice, satisfaction and outcomes. This was highlighted in our findings, in which respondents emphasised the importance of the workforce reflecting and representing local communities, and the importance of seeing Black and Asian staff in leadership positions. Respondents also shared that when they saw or were cared for by a healthcare professional from a similar culture or ethnic background, they often received better quality care. Respondents felt this was because the healthcare professional could understand and be more sensitive to their cultural needs and preferences.

Retaining a diverse workforce

Providers and commissioners have put measures in place to ensure their ethnically diverse staff are given opportunities for career development and progression. For example, CLCH and HCT are encouraging their ethnically diverse staff to undertake mentoring, leadership and management training, with CLCH seeing 43 band 4 to 6 nurses completing the CapitalNurse BME Leadership programme.

Both Trusts have seen an improvement in the number of ethnically diverse staff accessing training programmes and continuing professional development. It is important that all Trusts and bodies within the new ICS support their ethnically diverse staff and retain a diverse workforce by ensuring they are given equity in opportunity to develop professionally.

Supporting ethnically diverse staff

Providers and commissioners are committed to ensuring that their ethnically diverse staff are treated both fairly and equally. For example, HPFT found that a disproportionate number of their ethnically diverse staff were working through the disciplinary procedure. The Trust set up a "First Decision Making Panel" for staff to be referred to before facing the disciplinary procedure. This ensured objectivity and since, there has been a significant decline in the number of ethnically diverse staff facing the disciplinary procedure (0.79 compared to the national average of 1.14[15]). This initiative has been cited as an example of best practice at a national level.

HPFT also found that a large proportion of their ethnically diverse staff are experiencing racist abuse from patients and carers using the service. HPFT has put up posters and is reminding patients and carers about

[15] Workforce-Race-Equality-Standard-report-2021-.pdf (england.nhs.uk)

the importance of respect and its zero tolerance towards racism. The Trust is also encouraging its ethnically diverse staff to report racist abuse and discrimination, and is working closely with the police to safeguard its staff.

Similar incidences are happening at WHTH, in which ethnically diverse staff are experiencing microaggressions and abusive behaviour from patients and carers. The Trust is providing ongoing pastoral care for its ethnically diverse staff to ensure they feel safe and supported in the workplace.

These initiatives for supporting ethnically diverse staff both professionally and personally are examples of good practice which other Trusts and CCGs should take forward in their own organisations.

Staff culture

Trusts and both CCGs told us that they are committed to embedding the values and principles of equality, diversity and inclusion into the culture of their organisation. For example, anti-racism is referred to within HPFT's values and strategies, and HCT is in the process of launching a statement on its website about how the Trust is anti-racist. At an ICS level, the system has committed to developing activity in response to the East of England anti-racism strategy.

Each Trust also has, and the CCGs at the time had, their own "BAME Staff Network" which provide an open forum for ethnically diverse staff to share their experiences of the workplace in a supportive and confidential environment. The networks help shape the inclusion agenda for the organisation, as well as initiatives for improving ethnic equality for staff and patients. Some Trusts have introduced "reverse mentoring" for staff, in which White members of staff are assigned an ethnically diverse member of staff to educate them about their experiences of working for the Trust from their perspective, and the challenges they can face both personally and professionally due to their ethnicity and culture.

Providers and commissioners are ensuring they discuss race and culture within their organisation through using a variety of communications, including videos, podcasts, social media and staff stories. Trusts and CCGs told us they have also been holding conversations on difficult topics such as discrimination and racism through their forums, networks, conferences and Board meetings, many of which are led by their Chief Executive or staff in senior positions. Regular conversations on race and culture are also delivered through team meetings and initiatives such as "Lunch and Learn" which were hosted by the CCGs, in which a recent discussion on White privilege was attended by over 100 staff members.

It is important that providers and commissioners continue to build a culture in their organisation which openly discusses race and culture, and encourages staff to have challenging conversations about these issues. Embedding an inclusive culture will help ethnically diverse staff feel safe and supported in the workplace, but will also help all staff to deliver person-centred care by having a greater awareness and understanding of the importance of cultural sensitivity.

Engagement with Black and Asian communities

Some providers and commissioners are part of wider networks and/or work with larger community and voluntary groups which focus on all ethnic groups, or equality, diversity and inclusion more broadly. While the ICS has created the Joint Strategic Commissioning Board for Health Creation and Voluntary Community Faith and Social Enterprise (VCFSE) to address health inequalities, and has funded the Covid Recovery Ethnic

Diverse Project (CRED) as well as smaller community groups such as the Adda Club to support engagement with ethnically diverse communities.

However, none of the Trusts or CCGs were engaging directly with local grassroot organisations within Black and Asian communities. Although they all recognised a need to build relationships with local community groups, they tend to focus on engaging with ethnically diverse groups more generally, rather than Black and Asian people specifically. Trusts and CCGs also noted that a key barrier preventing them from engaging with local communities is the lack of resource and capacity they have to carry out outreach and engagement work, both internally and externally.

Without listening to and working with Black and Asian communities themselves, providers and commissioners will not be able to understand or address their specific health needs. As mentioned previously, services cannot rely on Population Health Management to understand ethnic health inequalities, but need to combine this with the expertise and lived experience of the communities directly affected. Engagement with Black and Asian groups is also particularly important, in the light of our findings highlighting a deep mistrust amongst Black and Asian people towards the NHS, with a large number of respondents believing their health is not equally protected. Building relationships with local Black and Asian community and faith groups is essential in rebuilding their trust and confidence in the NHS.

Similarly, it is important that providers and commissioners do not only engage with Black and Asian communities when it suits their needs or agenda. Trusts and the new ICS need to build trust with these communities, and ensure that relationships are genuine and sustained.

Summary

It is clear that providers and commissioners are committed to tackling ethnic health inequalities and improving the quality of care that Black and Asian people receive. However, this report has demonstrated that there is work left to be done and highlights opportunities for improvement.

It is crucial that different ethnic groups are not homogenised into a single category by using generic policies, using communications and imagery that are not reflective of groups or by inadequately collecting and reporting ethnicity data. Understanding specific groups' needs is essential for identifying where inequalities lie and then working to address this by providing equal and inclusive care.

It's also important that people's individual needs are met through a tailored, personalised approach to care. This is not just through communications and policies, but by ensuring that patients are listened to and heard when accessing healthcare. This will not only help services to provide a higher standard of care, but will also demonstrate that patients from ethnically diverse communities are valued and respected.

Broadly, more work needs to be done in rebuilding trust with Black and Asian people and providing culturally competent care which respects and accommodates for their needs, preferences and requirements - whether that be ethnic, cultural or religious. As the ICS comes into force, there is great opportunity for providers and commissioners to engage with Black and Asian community groups across Hertfordshire to better understand what they require from the healthcare system. By working together, services can work to understand and address issues with healthcare and provide fair and equal care for everybody, regardless of race, ethnicity, religion or culture.

Conclusion

The findings show there is a clear mistrust in the NHS amongst Black and Asian communities, with respondents feeling that the NHS does not protect their health as equally as it protects the health of their White counterparts. This lack of trust stems from their own lived experience, and the experiences of their family, friends and community members, but also more broadly, with respondents referencing how the COVID-19 pandemic disproportionately affected Black and Asian groups, and the existence of ethnic health inequalities more generally.

Respondents also shared that they believed they had been discriminated against in a healthcare setting because of their ethnicity. Examples included mistreatment from healthcare professionals and the use of racial stereotypes, both of which led to inadequate care and feelings of unequal treatment. The lack of cultural competency within services also made respondents feel disrespected, with many respondents not having their language, dietary, religious or cultural needs respected or accommodated.

Lack of training and understanding amongst NHS staff was noted, with healthcare professionals not always understanding how conditions may present on darker skin, and therapists not grasping the influence of culture on a person's mental health. In some cases, this lack of understanding led to late or incorrect diagnosis, impacting the individual's health and wellbeing . These experiences often resulted in Black and Asian patients feeling they have not been listened to, and a need to advocate for themselves so they receive the same level of care as their White counterparts.

In terms of our engagement with the NHS, it is clear providers and commissioners are committed to tackling ethnic health inequalities and improving the care Black and Asian communities receive. NHS needs to avoid homogenising all non-White groups and look to meet and address the needs of specific ethnic groups so that they can better understand health disparities within their services, and between different ethnic groups. This will also support services in providing tailored and personalised care, enabling Black and Asian patients to feel valued and heard. NHS services also need to improve the cultural competency of their services, by providing this training to all staff and embedding a culture in their organisation that provides equal, fair and inclusive care for all patients, regardless of their race, ethnicity, religion or culture.

In conclusion, the findings presented in this report reflect what we already know from national findings, clearly demonstrating that health inequalities, discrimination and deep mistrust negatively impact the healthcare experience of Black and Asian Hertfordshire residents, and the need for our local NHS to take action on addressing these disparities and concerns.

Importantly, this report is the first of its kind which, on a local level, explores the healthcare view and experiences of Hertfordshire's Black and Asian communities. It also highlights the changes they want to see for tackling ethnic health inequalities, and providing fair and equal care.

Role of the ICS and Health and Care Partnerships

Following its formal establishment in July 2022, the ICS and its place-based Health and Care Partnerships (HCPs), now play an important role in tackling health inequalities across the system, by bringing together NHS organisations with local authorities and the voluntary and community sector and facilitating collaboration between these organisations. Based on national evidence and the findings from our report, the ICS and HCPs should help support services in addressing ethnic health disparities by:

- Providing leadership for tackling ethnic health inequalities, advocating and asserting this issue as a key priority for all services.
- Promoting the use of community-based interventions and working with community leaders to ensure services use their expertise and insights, and have an understanding of their specific needs.
- Encouraging services to work together in a more joined-up way on community engagement within their local systems.
- Supporting staff across the system to increase their knowledge and understanding of ethnic health inequalities.
- Encouraging services to share good practice, learning, insights and resources.

Recommendations

We have made 16 recommendations to providers and commissioners for improving the healthcare experience of Black and Asian patients and for tackling ethnic health inequality.

Improving the collection and recording of patient ethnicity data to better capture the health outcomes of Black and Asian patients

1. Hospital and Community Trusts should collect at the minimum 85% and 61% of patient ethnicity data respectively across each service and monitor progress towards these targets. [16]
2. Providers should improve the collection and recording of patient ethnicity data by:
   a) Ensuring progress towards meeting this target is made available to the public in an accessible and transparent way to ensure accountability.
   b) Encouraging and expecting staff to record and collect patient ethnicity data through staff training and education.
   c) Working with the community and voluntary sector who have established linked with Black and Asian communities to encourage patients to share their ethnicity by reassuring them how this information will benefit their care and others.
3. To effectively hold providers to account, commissioners should specifically request patient ethnicity data from providers. The recording of this data should be consistent across all providers and of high quality.
4. Providers and commissioners should be clear on the types of disparities they are addressing and how. This information should be available to the public and easily accessible.

Ensuring complaints and feedback systems are more accessible and approachable, enabling Black and Asian patients to feedback with confidence

Using national evidence and the findings from our report, providers and commissioners should ensure their complaints and feedback systems are accessible and approachable by:

5. Capturing and recording patient ethnicity data to better capture who is providing feedback.
6. Encouraging Black and Asian patients to feedback and/or complain by reassuring them that this is an independent process which will not affect the care they receive.
7. Proactively gather feedback in real time, with the recognition that Black and Asian patients are less likely to complain.

[16] 85% is the national average for the collection of patient ethnicity data for Hospital Trusts, and 61% is the national average for the collection of patient ethnicity data for Community Trusts. Data available at: Ethnicity coding in English health service datasets (nuffieldtrust.org.uk)

Building and sustaining genuine relationships and partnerships with Black and Asian communities

8. Providers and commissioners should continuously engage with Black and Asian communities to build sustained, trusting relationships by involving them at all stages of service development, delivery, evaluation and improvement.

Ensuring that healthcare professionals are aware of, and responsive to, the cultural preferences and sensitivities of Black and Asian patients

Training

9. The uptake of Equality, Diversity and Inclusion training and other supporting programmes should be recorded and monitored.
10. Equality, Diversity and Inclusion training, as well as supporting programmes, should be offered to all staff, including staff that are not frontline. Supporting training programmes could be:
    - Cultural competency
    - Unconscious bias
    - Anti-racism
    - Understanding disparities and health inequalities.

Communications

11. Communications from providers and commissioners should be culturally competent by:

a) Recording language preferences and ensuring the appropriate translation and communication support is provided if required.
b) Within communications, avoid using the term "BAME" and use language that reflects the specific ethnic group the communications refer to, for example "Black Caribbean" .
c) Within all communications, ensure the imagery used reflects the ethnic diversity of service users, or the specific ethnic group the communications refer to.

Improving the recruitment, representation and retention of Black and Asian staff to ensure a more diverse workforce, reflective of the community it serves

12. Providers and commissioners should continue efforts to improve the recruitment and retention of Black and Asian staff, particularly within senior positions, taking account of cultural differences within, as well as between, different ethnic groups.
13. Providers and commissioners should review and monitor their disciplinary procedures and panels to ensure the number of Black and Asian staff facing disciplinary is not disproportionate.
14. Providers and commissioners should support Black and Asian staff to report experiences of discrimination or abuse from either fellow staff or patients, and provide ongoing wellbeing support.
15. Providers and commissioners should create a culture of equality and respect by encouraging ongoing discussions around race, culture and ethnicity.

Implementing good practice

16. Providers and commissioners should consider the good practice that has been highlighted in this report and whether this can be adopted in their own services.

The responses to recommendations will be regularly monitored through our holding to account role, through which we regularly meet with health and social care leaders to raise patient concerns and ensure services are taking action to remedy such concerns.

Overview of the Responses to the Recommendations

The NHS has given powerful responses to the recommendations with practical steps to address the issues raised. There is commitment from the NHS to taking urgent action in tackling ethnic health inequalities and ensuring Black and Asian people feel confident in accessing healthcare, and assured that they will receive fair and equal treatment. The full responses can be found in the appendix.

Improving the collection of patient ethnicity data: Providers have committed to improving the collection of patient ethnicity data, with HCT launching annual 'Clinical Systems' training to ensure staff are aware of the importance of capturing complete and accurate ethnicity data. To support, the ICB Nursing and Quality Team will promote this requirement through its Quality Review meetings and Quality Assurance visits, as well as through quality and contractual monitoring. Providers will also use this data to improve services, with CLCH implementing an Equity of Access dashboard using equalities data to identify priority groups and gaps in provision.

Ensuring feedback systems are more accessible and approachable: The NHS will improve feedback and complaints systems by ensuring ethnicity data is recorded when collecting feedback, and by encouraging Black and Asian people to share their experiences. Feedback will be analysed to make service improvements and to ensure Black and Asian patients are receiving fair treatment.

Building relationships with Black and Asian communities: The NHS is building relationships with Black and Asian communities and have created long term plans to rebuild trust and ensure Black and Asian people have greater confidence in accessing healthcare. For example, CLCH has launched a pilot to understand the causes of mistrust amongst ethnically diverse communities and will hold workshops with them to coproduce solutions.

Ensuring healthcare professionals are aware of and responsive to the cultural preferences of Black and Asian patients: The NHS is expanding its training programmes, with CLCH, ENHT and the ICB launching cultural competency training. HPFT is looking to hold specific training at population level with a focus on individual communities and cultures, while WHTH has recruited a Workforce Equality, Diversity and Inclusion Lead to build an inclusive training programme for staff. The NHS will also continue to improve its communications, ensuring inclusive and culturally sensitive language and imagery is used. Improvements to the provision of translation services are also in place, as well as ensuring patients are made aware of the support available.

Improving the recruitment, retention and representation of Black and Asian staff: The NHS is very committed to instilling a culture of equality within their own organisations and across the system. Examples include the ICB and ENHT embedding the East of England anti-racism strategy, and HPFT and WHTH holding frequent discussions on race, culture and ethnicity within the workforce and at senior level. These values are also embedded within their policies, with HCT drafting a new Equality, Diversity and Inclusion strategy, of which anti-racism is at its core.

Five year plans are in place to recruit more ethnically diverse staff and to increase the number of ethnically diverse staff in leadership positions – this will be monitored by the ICB. To support and retain staff, HPFT and WHTH are investing in the development of ethnically diverse staff with a particular focus on leadership. The ICB will also implement a pre-disciplinary panel as this has been shown to ensure ethnically diverse staff are not disproportionately facing disciplinary procedures.

In outlining their commitments, the NHS recognises the scale of such challenges should not be underestimated, overall more needs to be done and systemic change is needed to address the years of mistrust and poor treatment Black and Asian communities have experienced.

Appendix

Responses from local providers and the Hertfordshire and West Essex Integrated Care Board (ICB)

NHS
Central London
Community Healthcare
NHS Trust

Response from Central London Community Healthcare NHS Trust (CLCH)

CLCH Equality Strategy

CLCH's Promoting Equality and Tackling Inequality Strategy aims to reduce the unfair and avoidable inequities in access to healthcare, experiences of care and outcomes where differences are borne from barriers relating to one's protect characteristics.

This strategy was launched in 2021 and will run until 2025. Achieving sustained developments in healthcare experiences requires co-production with members of the community and these processes take time. Therefore, unless stated otherwise, actions outlined in this response will fall within the Strategy's timeline.

The following sections are the CLCH response to each of the themes presented in Healthwatch Hertfordshire's *Making Local Healthcare Equal: Healthcare Concerns in Black and Asian Communities* report. Beyond the theme responses and where appropriate we have outlined details of initiatives; we have developed to mitigate against issues of health inequality for BAME communities.

Mistrust in healthcare

The notion held by Black and Asian survey respondents that the NHS shows racial disparities regarding the protection of health of people is one that we are aware of and seek to remedy to work towards equitable access to services.

Building Trust with Members of the BAME Community Project

We are currently engaged in a pilot in the London Borough of Hammersmith and Fulham, "Building Trust with Members of the BAME Community." The scheme, which started in July 2022, aims to understand issues that cause distrust of healthcare services. Workshops will be held in January 2023 with members of the BAME community to not only gather views and experiences but to also co-produce solutions to the issues. From April 2023, working groups will be formed with the community, the local authority, healthcare providers from the North West London Integrated Care System and members of the voluntary and charity sector to facilitate a joined-up approach to mitigating against issues of mistrust. From June 2023, the community-led working groups will lead on improvement plans.

We hope to use the findings and recommendations from these schemes of work to build trust in the other localities that the Trust serves and build relationships with Black and Asian communities.

Lived experience: discrimination

That such 45% of survey respondents indicated that they felt that they were racially discriminated against whilst in a healthcare setting is a shocking finding. Be it through facing prejudice upon arrival or not being understood by staff, the Trust position is that access to healthcare is to be equitable for all races and ethnic groups. In practice, this entails booking sufficient time for service users to express to themselves in appointments and empowering patients to know that where a language/communication barrier may exist, they have the right to book an interpreter to facilitate the conversation.

There is the additional issue concerning service users with Western/Christian names who sense a palpable change in tone, demeanour, or engagement upon engaging with NHS staff. Though such experiences are felt, we are aware that they can be difficult to report or challenge. It should be noted that the CLCH PALS and complaints processes are open to all service users (including parents, guardians, carers etc.) and all formal complaints will be responded to within 25 working days, informal PALS concerns are responded to and resolved within 5 working days.

Culturally competent care

CLCH takes pride in the fact that our staff hail from diverse ethnic backgrounds. Though representation alone is insufficient to prevent the prejudices that service users may face, equitable treatment necessitates empathy and an improvement in the cultural competency of our staff, irrespective of ethnicity.

Educating the workforce on cultural expectations and understanding of conditions that affect BAME groups disproportionately or present differently has been evidenced to mitigate against prejudices that lead service users having divergent and substandard experiences of care. The Trust is in the process of developing action plans in response to its Workforce Race Equality Standard (WRES) findings. There will be a further offer of training for staff to improve cultural competencies around bias, language, and negative behaviours. The target date for completion of this scheduled for June 2023.

Anchor organisation

Furthermore, it is an Equality Strategy objective for CLCH to improve in efforts to recruit from the local populations we serve to fulfil its ambition to truly be an anchor organisation within the community.

We are also engaged in qualitative work with the community, seeking to improve our cultural awareness of end-of-life care. Come October 2022, we will hold focus groups and interviews with members of the Black African and Black Caribbean communities to understand expectations regarding care towards the end of life and to be guided on how to engage with communities on what is a challenging topic.

Language Barriers

Part of improving our cultural competency will be achieved through enhancing our signposting and educational offers in commonly spoken languages across CLCH's communities. For those awaiting treatment, we aim to develop resources, both in print and digital formats, that inform service users of how they can be supported from the point of referral to discharge.

Additionally, in accordance with health inequalities action planning across the Trust, we aim to standardise the promotion and provision of interpreting services for service users who stand to benefit from

communicating their health needs in languages other than English. The improved offer will entail a systematic approach to asking whether an interpreter is desired at the point of referral and may provide further reminders in referral letters as well as enhanced signage on view for those in waiting rooms ahead of their appointments.

Not feeling heard

CLCH aims to embody patient-centred care by engaging with service users before making changes that affect them. Utilising aspects of the "nothing about us without us" approach, changes made through policy, projects and service improvements should be built upon patient engagement as a prerequisite.

The Trust's Patient Engagement Group (PEG) holds is a monthly meeting at which service user feedback, in the form of Friends and Family Tests (FFTs), compliments, patient stories and complaints, are reported to for progress monitoring and resolution. This qualitative feedback enables the Trust to act on issues that service users feel affect their experiences of care.

Divisional Health Equalities Action Planning

Building on the Trust's aim to identify key areas of health inequalities within its services, each of the Trust's five divisions is engaged in a programme where they are to develop Divisional Health Equalities Action Plans. The timeline of this scheme is as follows:

Aug 2022 – Each CLCH Division to complete the health equalities action plan template, detailing what they plan to do around improving access and supporting vulnerable populations.
Oct 2022 – Each CLCH Division to lead on an access / health inequalities initiative for vulnerable groups.
Mar 2023 – Each CLCH Division to have initial results to evidence initiative and mitigations against health inequalities.

Equity of Access Dashboard

As of July 2022, CLCH recently launched the Equity of Access dashboard on PowerBI which allows teams to view activity, DNA rate and waiting times by protected characteristics (e.g., age, sex, ethnicity), deprivation and contact methods. We have presented the platform to Divisions and are encouraging teams to use it to look at their services from an equality lens and identify priority groups and take actions.

Ethnicity Recording

Efforts to improve awareness of health inequalities relating to ethnicity since March 2021 have improved ethnicity recording rates within CLCH towards 90% completion (approx..) though we are still working towards our target mark of 95%

Key issues affecting ethnicity recording include staff not feeling educated and empowered enough to ask about ethnicity. Furthermore, service users have felt natural scepticism as to why they were being asked a question about ethnicity that was, to them, seemingly unrelated to their healthcare.

We engaged in promotional campaigns to bridge the gap for both staff and service users to understand that ones' risk of harm from disease may be linked to their ethnicity as it is our duty as a public healthcare provider to ensure that we are proactive in identifying and predicting clinical need.

Summary

The findings of the *Making Local Healthcare Equal* report make for troubling reading for Black and Asian communities. We, at CLCH, understand that we are to change our approach to healthcare provision in a way that accounts for the cultural differences and expectations of our diverse populations to make our services truly inclusive.

Do let us know when the report is finally published. With your consent, we would like to share these findings and recommendations with the CLCH Equalities Group for us to develop improvements with the wider platform concerned with the governance of our Equalities Strategy.

Response from West Hertfordshire Teaching Hospitals NHS Trust (WHTH)

Improving the collection and recording of patient ethnicity data to better capture the health outcomes of Black and Asian patients

The Trust has a mechanism to capture ethnicity data via EPR as well as patient health records.

We will review the current process in relation to capturing ethnicity using digital systems such as EPR including how patients understand the importance of sharing ethnicity.

This will provide us with an understanding of our compliance which will in turn allow us to identify gaps to support identification of mechanisms for ensuring sustained compliance.

Ensuring complaints and feedback systems are more accessible and approachable, enabling Black and Asian patients to feedback with confidence

The Trust has a complaints process as well as mechanism for patients to provide feedback via PALS and the Friends and Family Test.

Language line (translation) is available to ensure effective communication.

We will review our current process to understand if ethnicity is recorded as part of a thematic analysis of complaints.

We will review both formal and informal processes to capture feedback from all patients regardless of their ethnicity and whether this is a responsive process to encourage sharing experiences both positive and negative.

We will review the process that encourages patients to provide feedback and demonstrate that it has made a difference ('you said we did').

Building and sustaining relationships genuine relationships and partnerships with Black and Asian communities

The Trust has a co-production board, co-chaired with Healthwatch, we will work collaboratively and continue to build on these recommendations considering the National Patient safety strategy.

We will evaluate the effectiveness of this process and how it can provide assurance.

Ensuring that healthcare professionals are aware of, and responsive to, the cultural preferences and sensitivities of Black and Asian patients

The Trust has committed to this agenda by recruitment to:

- A OD and Culture lead who will assist in the development of a positive organisation culture

- A Workforce Equality, Diversity and Inclusion lead with a remit to build an inclusive training program for all staff

Our Clinical teams will work with our Equality, Diversity & Inclusion Lead to ensure that training is delivered to the workforce by clinical experts. We will align with the WRES action plan.

Better care delivered differently is the Trusts five-year change strategy with a EDI remit. Program 3 as part of this includes personalised care with attention to promoting equity and diversity across all systems.

We will review the current strategy and incorporate the recommendations from this report.

Communications

We will review the Trust website and the process of publishing patient information to ensure inclusive language is used.

The Trust has a staff support network, CONNECT as part of these recommendations the Trust will work closely with CONNECT to ensure our communication strategy is refreshed and responsive considering these recommendations. This will include a monitoring & compliance process as part of the strategy.

Improving the recruitment, representation and retention of Black and Asian staff to ensure a more diverse workforce, reflective of the community it serves

The Trust is in the process of reviewing and updating the recruitment and selection policy.

The plan is to identify a robust methodology to ensure we have an inclusive recruitment process.

Recommendations from our WRES report will encourage promotional opportunities:

- Ensure higher take up of targeted coaching sessions to Black & Asian & Minority Ethnic group staff employed at Band 8b-8d
- Targeted skills development and assessment days for Black Asian & Minority Ethnic groups of staff employed in Bands 7-8a (Medical and Non-Medical)
- Explore the reasons that Black, Asian & Minority Ethnic groups of staff make up 59% of Consultants compared to 75% of Non-Consultants
- Launch a new Secondments Bureau

The Trust's WRES action plan in order to improve the outcomes of staff in this group as outlined in the recommendations.

Examples are:

- Confidential themes from Staff Networks' safe space sessions to be fed back to EDI Steering Group at least twice a year
- Embed Connect proposed changes to disciplinary process from September 2021. [Connect request the Disciplinary Panel and Triage Panel to be diverse and to include a trained Inclusion Ambassador]
- Freedom to Speak Up Champions are diverse, including representing our multicultural workforce, which encourages reporting and offers support
- We have a Wellbeing team who run regular events and prioritise Re-energising the workforce. They also fund the EAP scheme which is promoted to all staff on a regular basis.

- The successful reciprocal mentoring between White top managers and Black, Asian & Minority Ethnic employees, as well as the 6-weekly 'global workforce events' run by Connect, both serve to encourage respectful discussions around race, culture, and ethnicity

Implementing good practice

The Trust has an established network within the ICS. We will review the process of shared learning focusing on the recommendations and that the agreed refreshed process is responsive.

This will be captured in a report to the EDI steering group.

Response from East and North Hertfordshire NHS Trust (ENHT)

Thank you for giving us the opportunity to respond to each of thematic recommendations set out within the Making Local Healthcare Equal report shared with us last month. We have had the opportunity to review this and have shared it with our trust equality and diversity lead. We are very committed to continue to working with you once this report is published and shared more widely, ensuring that the recommendations set out within the report are implemented and monitored across Hertfordshire.

Improving the collection and recording of patient ethnicity data to better capture the health outcome of Black and Asian patients

We fully support this recommendation and have steps in place to capture this information, including health outcomes, as we develop plans for our full electronic patient record system.

Ensuring complaints and feedback systems are more accessible and approachable, enabling Black and Asian patients to feedback with confidence

The trust are improving the way we capture complaints data to ensure that we can accurately record demographic data, including the recording of protective characteristics. We recognise that are some gaps in our translation service with means some gaps in the access to information. This is being addressed. The way in which we encourage feedback is being reviewed in light of this feedback and we will incorporate these specific recommendations into our trust wide complaints improvement programme.

Building and sustaining genuine relationships and partnerships with Black and Asian communities

The trust has an active engagement programme with the wider BAME community but there are areas for further growth and development. We have engaged with the Stevenage World Forum and will continue to link with them and the wider community to ensure more is done. Specific examples of this engagement work include how we used these groups to support our vaccination programme.

We regularly invite members of the community to come and talk to the trust board on their lived experiences and to complement the staff story heard in at the trust board in May 2022 from the chair of our staff BAME network we will actively seek to hear the views of a patient or service user from the Black and Asian community at a future trust board.

The Trust has plans to increase marginalised communities involvement in research access and this is being monitored through our Research and Development Board.

The trust is implementing the Equality Diversity System (EDS) Plan which will focus on three core pathways – maternity, respiratory and mental health care.

a) Ensuring that healthcare professionals are aware of, and responsive to, the cultural preferences and sensitivities of Black and Asian patients

b) Improving the recruitment, representation and retention of Black and Asian staff to ensure a more diverse workforce, reflective of the community it serves

There is a trust wide EDI strategy in draft which incorporates several key priorities. This has already involved the following:

- Cultural Intelligence sessions – starting with The Board, executives, and senior leaders and with plans for a programme of masterclasses for the wider workforce.
- Embracing the East of England Anti-racism programme and this is being rolled out across the trust.
- Implementation of the SEEMEFIRST campaign
- Skills boosters for specific teams to be able to take forward the cultural issues and an eLearning module for staff to access
- Development of inclusion ambassadors at selection and interview process
- Development of inclusion and equity ambassadors across the trust

Implementing good practice

The Trust will embrace the good practice identified in this report and will use the partnerships in place across Hertfordshire to share further learning.

In conclusion, we fully support the report and will ensure that the recommendations are embedding into existing governance structures across the Trust.

NHS
Hertfordshire Partnership University
NHS Foundation Trust

Response from Hertfordshire Partnership University NHS Foundation Trust (HPFT)

Thank you for your letter received 28 July 2022, regarding the work that Healthwatch is tackling on ethnic health inequalities and the work with Black and Asian communities, to understand their attitudes towards, and experiences of, local healthcare. Thank you also for sharing your draft report 'Making Local Healthcare Equal: Healthcare concerns in Black and Asian communities' which includes the perspective of NHS services addressing ethnic health inequalities and improving the care Black and Asian people receive.

We are delighted that the report notes our strong commitment and support as a Trust in tackling ethnic health inequalities and note the recommendations which have been made.

In consideration of the response requested to each theme in the report, I am writing to provide you with some detail regarding what we have already done and are further planning to do against the themes.

Governance

The Trust is a member of the Hertfordshire Mental Health Inequalities Group, chaired by Kate Linhart (Deputy Director, Integration and Partnerships) on behalf of the Collaborative, which reports into the Mental Health, Learning Disability and Autism Collaborative. The external governance from the Integrated Care System (ICS) is developing and the Inequalities Group is now chaired by a Non-Executive Director (NED).

Cultural Competence

The Trust and ICS will look to develop cultural competencies in relation to ethnic inequalities, with a view to move beyond a homogenised approach (EDI training), to specific training at local population level – for example, a high Bangladeshi population in St. Albans, and will ensure that staff have a clear understanding and awareness of customs, culture and community assets. To enable and ensure the diverse needs of our populations are fully met, there is an opportunity to review how we commission and support communities to deliver care.

Patient (service user) Ethnicity Data

Kate and Michael Thorpe (Deputy Director, Improvement & Innovation) are working with Public Health and relevant groups to develop an evidence-led approach to improving outcomes for Black African and Afro-Caribbean communities and develop more sophisticated volume data, which we have triangulated with national data. Kate will be working with community leaders over the next few weeks to utilise data from the VCSE as well as from the Healthwatch report and also a report from the North Health Ethnic Inequalities Commission.

Engagement

Engagement has been a challenge, as noted in the Healthwatch report, in consideration of both trust within the statutory organisations, competing for the limited resource offered and the processes to obtain grants. Kate is meeting with a number of individuals and community leaders over the next couple of weeks to work through some of these challenges and develop an effective engagement approach. Kate is also in discussion with both David Evans (Executive Director, Strategy and Partnerships) and Beverley Flowers for resources to

pay organisations for their engagement (as we do in the Trust with Experts by Experience) to enable more meaningful collaborative working.

With our IAPT services we have appointed 2 EDI senior clinicians and have developed a directory of local organisations. We are working with them to explore how we can deliver culturally relevant support to local communities. Contact has been established with a local Ethnic Minority group in St. Albans and staff attended a local Eid event as a networking opportunity in July. Planned events include attending the International Students Fair at University of Hertfordshire in September and delivering a workshop to all GPs to encourage an increase in referrals for ethnic minorities.

Culturally sensitive clinical skills groups have been delivered to all new staff and are being rolled out across all staff groups in the coming months. Attendance at "let's talk about race" events have been helpful in identifying and addressing difficulties experienced by staff from white and non-white backgrounds and people from the differing races they support.

Over the past 12 months, we have continued with our reverse mentoring programme and established a Black Asian Minority Ethnic (BAME) staff support line during the COVID pandemic. We have also amended the disciplinary process and the first decision making panel, which has resulted in a significant reduction in the relative likelihood of BAME staff entering the formal disciplinary process, compared to white staff. BAME staff, as a result, are now less likely to enter the formal process. We have an active BAME network, sponsored by an Executive Director and have introduced Inclusion Ambassadors to support areas such as recruitment. Our mandatory Equality, Diversity and Human Rights training for all Trust staff is currently at 95% compliance.

Understanding Health Inequalities

Building on the above, the conversations will help to develop a shared vision and take increased action as a system, learning from the Covid pandemic and system learning and working.

Further actions which are being progressed, include:

- The launch of a staff app to improve the quality of staff data on protected characteristics, including ethnicity
- Creating an award category at our annual Staff Awards for people who champion belonging and inclusion
- Investing in BAME staff talent management, supporting BAME staff development and BAME leadership development to increase the number of BAME leaders, with a 36% target to mirror the proportion of BAME staff Trust-wide
- Taking positive action in favour of BAME applicants in our recruitment processes
- Equip our leaders with the skills to have safe and supportive conversations about equality and inclusion
- Take action to ensure white staff are skilled to be visible allies

Furthermore, we will launch a bigger engagement piece to support the development of our new Including and Belonging Strategy in the Autumn 2022, with plans to use a wide range of bespoke events as well as our regular events and other opportunities to seek the views and capture feedback. We have held a number of focus groups over the summer to help position the discussions.

Response from Hertfordshire Community NHS Trust (HCT)

Improving the collection and recording of patient ethnicity data to better capture the health outcomes of Black and Asian patients

HCT is committed to improving the collection and recording of patient ethnicity data to better capture health outcomes of Black and Asian patients. We recognise the importance of this and the issues, challenges and need for improvement in relation to patient ethnicity data and support the report's recommendations.

Our Clinical and Quality Strategy 2021-25 has reducing health inequalities as one of its 5 priorities and this strategy and the Trust's Health Inequalities Plan identifies the following key priorities within this:

- Develop a better understanding of the inequalities experienced by different populations we serve
- Improve access to care
- Improve equality and experience of care
- Reduce inequality of outcome between populations experiencing inequalities and the wider population.

There are two specific actions within our Health Inequalities Plan which relate to the collection and recording of patient ethnicity data and understanding of health outcomes for Black and Asian patients as recommended in this report:

- Provide equity of access to services for all (as measured by referral levels, waiting times, consultation method), ensuring that there is equity of access for those with protected characteristics (including by ethnicity), those from more deprived areas and those with a reasonable adjustment flag. Complete analytics to identify potential inequality of access and evaluate whether intervention is required.

- Develop a robust, validated outcomes dashboard. Align outcomes dashboard to population health analysis, facilitating services to improve their understanding of the demographic makeup of the population they care for and outcomes associated with these groups. Analyse whether outcomes are equitable regardless of patient or service user's ethnicity, protected characteristics, deprivation level or reasonable adjustment flag. If analytics suggest outcomes differ, targeted interventions to be formulated.

In relation to recommendations 1-4 of the Healthwatch report, we have the following in place:

- A patient profile is completed for each new patient/service user on our electronic clinical system and staff are prompted to record the patient's ethnicity. The clinical system template includes a dropdown menu to support use of valid ethnic group codes.
- Each month, service leads attend an Operational Performance Review (OPR) meeting and one of the performance metrics reviewed at service level is completeness of ethnicity data.
- Data Quality reports are available via our clinical system to enable services to identify and rectify data quality issues, including missing ethnicity data.

- The Trust's overall performance on ethnicity reporting is included in the Performance Dashboard which is shared at each Public Board meeting. In addition, at the monthly People Performance and Finance Board Committee, the Service Recovery and Performance Report provides Trust-level analysis of waiting times by Index of Multiple Deprivation (IMD) and ethnicity grouping.
- All new staff who will use our clinical systems receive Clinical Systems training which emphasises the importance of complete and accurate data capture, including ethnicity.
- In addition, annual Clinical Systems refresher training has recently been introduced which again covers importance of data quality.
- In addition to the Health Inequalities Plan actions noted above, we will also take further action to improve collection and reporting of ethnicity data as follows:
    - Review recommendations and best practice in relation to ethnicity data collection and reporting e.g., Nuffield Trust report 'Ethnicity coding in English health service datasets ' and good practice at other provider trusts.
    - Increase focus on improving collection of ethnicity data using existing mechanisms e.g. Trust communications, clinical systems training, OPR and use of Data Quality reports.
    - Review service and Trust level ethnicity reporting to ensure this is as useful as possible e.g. that 'not stated' percentage is explicit, as well as the percentage reporting a valid ethnic code and ensure consistency of reporting.

Ensuring complaints and feedback systems are more accessible and approachable, enabling Black and Asian patients to feedback with confidence

5. Capturing and recording patient ethnicity data to better capture who is providing feedback.

We will enable our Patient Experience Team to access patient ethnicity data held on the electronic patient record in order to provide this information direct from the system where appropriate. We also plan to link with community providers through the Director of Nursing Network to see if there is other learning we can take forward.

6. Encouraging Black and Asian patients to feedback and/or complain by reassuring them that this is an independent process which will not affect the care they receive.

Our recently re-established Community Engagement Forum (which was paused during the pandemic) will help us to engage directly with Black and Asian's communities to encourage feedback and inform them about how they can raise a complaint about our services via the dedicated patient experience team. We will provide reassurance that raising a complaint will not affect care that is received and inform people about how local independent NHS complaint advocacy services can be accessed.

7. Proactively gather feedback in real time, with the recognition that Black and Asian patients are less likely to complain.

Our Community Engagement Forum will support us in raising awareness in local Black and Asian communities about how they can feedback about their experiences and their preferred ways to do this. This will include real opportunities to shape and develop our services, for example in the Trust wide roll out of the service accreditation programme and through different service transformation projects. In addition, we will liaise with our Black, Asian and Minority Ethnic Staff Network to better understand how we can engage with our local communities and would welcome working with Healthwatch to develop and build relationships with Black and Asian leaders.

Building and sustaining genuine relationships and partnerships with Black and Asian communities

- Our Community Engagement Forum, which plans to meet quarterly, is part of our approach to this.
- We are working with other organisations in the ICS to develop joint community groups since we are all trying to access the same groups of people; this should be in place by the end of Q4
- We have updated our quality impact assessment to include equality impact assessment and health inequality impact assessment, which includes a requirement to consult with service users.

Ensuring that healthcare professionals are aware of, and responsive to, the cultural preferences and sensitivities of Black and Asian patients

9. The uptake of Equality, Diversity and Inclusion training and other supporting programmes should be recorded and monitored.

We have well-established processes for monitoring the update of our ED&I mandatory training (alongside other mandatory training) and review this at all levels of the organisation, including at Board sub-committee level. Our Learning Management System provides email reminders to staff whose ED&I mandatory training is due to expire and our compliance rate for July 2022 was at 96%. We also record other types of training relating to the ED&I agenda (see examples in answer to recommendation 10), although we do not monitor percentage uptake in the same way as mandatory training.

10. Equality, Diversity and Inclusion training, as well as supporting programmes, should be offered to all staff, including staff that are not frontline.

The various strands of ED&I training provided in the Trust are all offered to the full range of staff groups, not just front line. We have ED&I mandatory training for all staff as described above. We also have inclusion as a golden thread through our leadership training and have provided sessions on building inclusive teams, unconscious bias and anti-racism as part of our Leadership Conferences and Forums. We recognise the need to do more around cultural competence and are working with system partners on a programme to address this. We also recognise the need to review our provision around understanding disparities and health inequalities in the light of delivery of our Clinical Strategy.

11. Communications from providers and commissioners should be culturally competent by:

a) Recording language preferences and ensuring the appropriate translation and communication support is provided if required.

We will review and work to improve levels of recording language preferences and communication support.

b) Within communications, avoid using the term “BAME” and use language that reflects the specific ethnic group the communications refer to, for example “Black Caribbean” .

It is straightforward to use the specific ethnic group when only one group is involved and we would normally do this in the Trust. The difficulty is when a shorthand is needed for multiple ethnic groups. As an example, we do have a BAME Staff Network and we have discussed the term BAME with them on multiple occasions and offered to use a different term, but members are unable to agree a suitable alternative. We will continue to seek best practice on other ways to express this.

c) Within all communications, ensure the imagery used reflects the ethnic diversity of service users, or the specific ethnic group the communications refer to.

The Trust's communications team will continue to work to ensure that imagery used by HCT reflects the ethnicity of service users and will ensure that internal guidance provided to services reflects this.

Improving the recruitment, representation and retention of Black and Asian staff to ensure a more diverse workforce, reflective of the community it serves

12. Providers and commissioners should continue efforts to improve the recruitment and retention of Black and Asian staff, particularly within senior positions, taking account of cultural differences within, as well as between, different ethnic groups.

We operate 'blind' recruitment processes (i.e. no name or protected characteristic information for shortlisting) and we have recently introduced Inclusion Champions as part of interview panels for senior posts. This has resulted in success rates in applications for non-white applicants improving over recent years, although it is not yet equal. We also have lower representation of Black and Asian staff at senior levels, with the exception of our medical staff (75% of our medical Consultants are Black or Asian, albeit we only have 8 in total).

We are concerned that, in the same way the report shows a large proportion of Black and Asian patients see the NHS as a service for white people, so potential job candidates may not see us as an employer for them. We recognise the need to go much further in promoting job opportunities within our local communities and systematically breaking down barriers to enable Black and Asian job seekers to be interested in and able to access our roles. To do this we will need to listen to local job seekers to fully understand how we can make our roles and processes more attractive.

13. Providers and commissioners should review and monitor their disciplinary procedures and panels to ensure the number of Black and Asian staff facing disciplinary is not disproportionate.

We monitor this as part of our Workforce Race Equality Standard (WRES) reporting and we currently have an improving but still unequal position where Black and Asian staff are 1.44 times more likely to enter disciplinary procedures than white colleagues (1.00 would be equal). Last year we introduced a process whereby a checklist is completed for all Black and Asian staff where disciplinary action may be contemplated and then this is reviewed by one of our senior BAME Network members to ensure that there is no bias involved. We are now extending this to capability procedures.

14. Providers and commissioners should support Black and Asian staff to report experiences of discrimination or abuse from either fellow staff or patients and provide ongoing wellbeing support.

We have processes in place for this and have a variety of ways that staff can raise issues of discrimination and have them addressed, as well as a range of mechanisms to provide well-being support. However, we recognise that this is still an area for improvement. We are looking to strengthen routes for the reporting and resolution of issues, possibly by having a small cohort of trained senior managers who can step in to address concerns.

15. Providers and commissioners should create a culture of equality and respect by encouraging ongoing discussions around race, culture and ethnicity.

This has been a real area of focus for us over the last few years, with discussions taking place as part of Board development, leadership development and our Team Conversations to which all staff are invited. We actively engage with our Black, Asian and Minority Ethnic Staff Network and use Windrush Day and Black History Month to generate discussion and/or hold specific events. Work with our BAME Network has resulted in our current 'Be You' campaign, with daily Trust-wide events taking place in mid-September.

We have just drafted a new ED&I Strategy, which is very much an anti-racist strategy, and plan to use this as a further opportunity for engagement and discussion.

Implementing good practice

16. Providers and commissioners should consider the good practice that has been highlighted in this report and whether this can be adopted in their own services.

We are very much committed to addressing the areas set out in this report and adopting best practice where this is not already in place.

The areas set out in the report align well with objectives set out under our Clinical Strategy and new draft ED&I Strategy, and patient related aspects will continue to be taken forward to by our Health Inequalities Group. Staff related aspects are covered by our People Strategy, as well as the new ED&I Strategy, and these are monitored via our People and OD Strategy Steering Group.

Response from Hertfordshire and West Essex Integrated Care Board (ICB)

Dear Geoff,

Thank you for sharing your report with us. The Hertfordshire and West Essex Integrated Care Board (ICB) works hard to serve the public in a way that meets the needs of our diverse communities both in terms of commissioning health services and being an inclusive employer. We welcome the opportunity to respond to the findings in your report by theme and set out how we will continue to work to make improvements where needed.

Improving the collection and recording of patient ethnicity data to better capture the health outcomes of Black and Asian patients

All organisations delivering services under NHS contracts are required to not discriminate between or against Service Users, Carers or Legal Guardians on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation, or any other non-medical characteristics, except as permitted by Law. This requirement cannot be met without collecting and understanding equality data.

The Nursing and Quality team will promote this requirement through Quality Review meetings and Quality Assurance visits and adherence will be checked through quality and contractual monitoring.

Ensuring complaints and feedback systems are more accessible and approachable, enabling Black and Asian patients to feedback with confidence

The ICB's Nursing and Quality team, which works with the public on complaints and feedback which they want to pursue with us as commissioners, rather than the providers of services, are mindful that not all people wish to share their ethnicity at a time when providing feedback on services. They do not always understand the relevance of gathering this information. We will ask our staff to sensitively promote the rationale behind this approach, so we can improve the equality data we collect directly as an organisation.

This will help us to improve our response to individuals and communities, identify any themes that emerge or communities that are being disadvantaged, and better monitor whether communities are under or over-represented through the complaints process. As part of transparent and open governance processes, we will work towards providing a breakdown of the ethnicity of complainants to the ICB in our regular reports.

Through our new ICB website we have worked to make it easier for the public to understand which organisation is responsible for providing health services, and how to raise concerns or complaints with providers and commissioners. We have also included links to support and advocacy services, including POhWER, which provides NHS complaints advocacy leaflets in 27 different languages on their website, including a number of Asian languages. We also link to Healthwatch Hertfordshire and Healthwatch Essex, and the Parliamentary and Health Service Ombudsman. Web browsers allow this information on the ICB's website to be read in the written language setting which is the preference of the user.

Building and sustaining genuine relationships and partnerships with Black and Asian communities

This is an area in which the former CCGs/ICB/ICS has made notable recent progress, particularly in the light of learning from our area's COVID pandemic response.

Through successful work on the vaccine inequalities programme, our area received 'Contain Outbreak Management' funds, known as COMF funding, to run a community and grassroots grants process, which allocated grants ranging from £2k to £5k to local groups to support communities affected by the pandemic. Due to the amount of funding and to encourage grassroots (mainly volunteer run) organisations to bid, our ICS asked for light touch monitoring. These are some of the organisations which have benefitted from this funding, which was used to support those from Black and Asian communities with wide-ranging information and support on issues related to health inequalities – not just vaccine related concerns:

- Hertfordshire Asian Women's Association
- Al-Furqan St Albans – a community organisation and charity with a large BAME and Muslim audience. Providing trained bilingual volunteers to give the local BAME community confidential and objective advice and guidance on issues such as unemployment benefits, domestic violence, forced marriages as well as helping them fill out application forms for various services
- The St Albans Moroccan community
- The Dacorum Bangladeshi Welfare Organisation
- Hertfordshire Black Diaspora
- The Al Bayyinah community organisation

As a system, we need to learn from and promote community led successes, so that best practice can inform improvements across our area. Further work with Healthwatch and the Voluntary, Community, Faith and Social Enterprise (VCFSE) Alliance could assist in developing a methodology for assessing the appropriate levels of funding for VCFSE groups working with people from minority backgrounds, informing the VCFSE's health creation strategy.

The ICB has also developed closer working relationships with representative organisations, including the Afro GP group for Hertfordshire and Bedfordshire African GPs, to further understanding and community relations by learning from their expertise.

The role of social prescribing link workers is key in working with and supporting people from minority ethnic groups, and we have a diverse staff group of 80 BAME covid recovery workers supporting people in the heart of their communities and promoting cultural competence amongst their wider colleagues in health and social care.

At Place, Locality and Neighbourhood, our system needs to develop plans to address and support community development work, where the evidence suggests this will help address specific health inequalities.

Ensuring that healthcare professionals are aware of, and responsive to, the cultural preferences and sensitivities of Black and Asian patients

The Hertfordshire and west Essex Integrated Care Board requires all of our staff to undertake mandatory equality, diversity and inclusion (EDI) training. This training is recorded on each employee's personal records, and compliance with this requirement is closely monitored by the organisation. In addition to this mandatory

training, a range of EDI training, also recorded, is available to staff. This includes training on unconscious Bias, undertaking equality impact assessments, understanding white privilege, and microaggressions and civility.

Training and awareness raising for staff has also been provided on the NHS East of England-wide anti-racism strategy, launched in July 2021. At an ICS level, work is being undertaken to develop further training, including cultural competency training, in a way that is useful for participants and has a lasting impact.

11. Communications from providers and commissioners should be culturally competent by:

a) Recording language preferences and ensuring the appropriate translation and communication support is provided if required.

It is the responsibility of NHS service providers to ensure interpreting and translation services are made available to their patients, free at the point of delivery. General Medical Council guidance states that all possible efforts must be made to ensure effective communication with patients. This includes arrangements to meet patients' communication needs in languages other than English, as language is very important to providing optimal patient care. Working with language interpreters and translators reduces communication barriers between practitioner and patient and has been shown to improve safety with respect to diagnosis and prescription.

A patient's language and interpreting needs should be noted in their healthcare record, and this information should be passed on when referring patients to other health professionals.
In the light of Healthwatch Hertfordshire's report, the ICB will remind GP practices in Hertfordshire and West Essex of these obligations through its regular primary care communications channels. Information for the public about their rights to interpreting and translation services, as well as help with accessing NHS services for people with communications difficulties such as hearing impairments and learning disabilities, is also available on the front page of the ICB website.

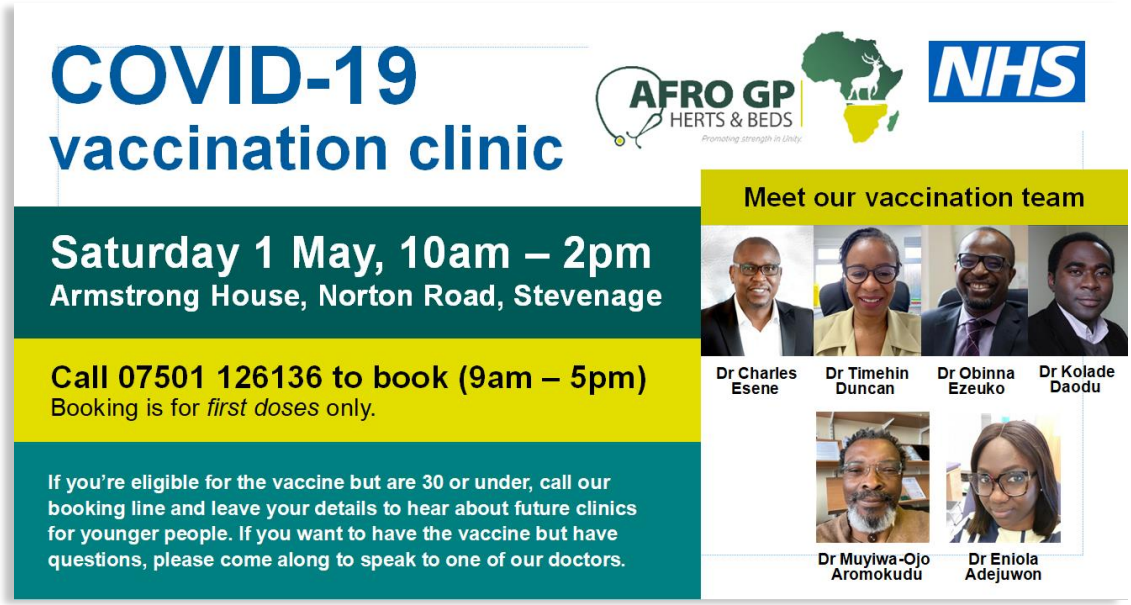
The ICB's communications and engagement team provides guidance and support when bespoke resources are required for people with different language requirements. For example, bespoke Easy Read information explaining local healthcare services was provided to Afghan refugees staying in an East Hertfordshire hotel, and culturally sensitive information about the COVID vaccination, addressing concerns from some north Hertfordshire Muslim groups, was provided for attendees at a Hitchin mosque.

Throughout the COVID-19 pandemic, the ICB's communications and engagement team has worked to ensure that written and video resources are readily available for the public in a range of commonly used written and spoken languages. The ICS led a bid for NHS Charities (Captain Tom) funding which paid for community groups to reach out to Black, Asian and minority ethnic communities and provide technology and training to the 'digitally excluded'.

b) Within communications, avoid using the term "BAME" and use language that reflects the specific ethnic group the communications refer to, for example "Black Caribbean".

There are times when the use of BAME/BME is necessary, such as when referring to the NHS Workforce Race Equality Standard for example, or the NHS staff BME networks, which were established in order to give greater prominence to race equality within the NHS, reduce health inequalities and target recruitment and development opportunities at people from black, Asian and other minority ethnic backgrounds.

However, in most circumstances, the communications and engagement team at the ICB takes great care to target communications explicitly at the communities that they are relevant to. Examples include bespoke leaflets and flyers produced featuring staff from the Watford Afro-Doc group of GPs (pictured below), information leaflets and videos featuring leading Muslim figures to promote vaccinations clinics in mosques (as evidence shows that South East Asian Muslims in particular have been less likely to take up their COVID vaccinations), and videos and leaflets featuring black African senior midwives designed to reassure pregnant black African heritage women, who are under-represented in vaccination statistics.



c) Within all communications, ensure the imagery used reflects the ethnic diversity of service users, or the specific ethnic group the communications refer to.

The ICB wholeheartedly supports this approach and use demographic information wherever possible to inform our choice of suitable images. A recent example is our summer COVID vaccination campaign, targeted at multi-generational families planning their first trips to see relatives abroad after the lifting of travel restrictions. Some example campaign materials can be found here:

Improving the recruitment, representation and retention of Black and Asian staff to ensure a more diverse workforce, reflective of the community it serves

12. Providers and commissioners should continue efforts to improve the recruitment and retention of Black

and Asian staff, particularly within senior positions, taking account of cultural differences within, as well as between, different ethnic groups.

All NHS organisations are working towards ensuring that the black, Asian and minority ethnic representation a) among its Staff at Agenda for Change Band 8a and above and b) on its Governing Body will reflect the black, Asian and minority ethnic representation in its workforce, or in its local community, whichever is the higher.

Providers are required to develop a five year action plan to achieve this and to share that with the commissioners. We will continue to require providers to produce and deliver on their action plan.

Commissioners have a target date for their compliance, set in the 'A Model Employer' report of 2019, of 2028. Work on this is built into our own ICB's workforce race equality action plan, and into a wider action plan which is already in place in our ICS area. It includes:

- an inclusion statement in all job descriptions
- equality, diversity and inclusion criteria in all person specifications
- equality, diversity and inclusion example questions to ask at all interviews, regardless of role / level
- inclusion ambassadors sitting on all interview panels for roles band 8a and above
- developing robust recruitment and selection training to include unconscious bias, best practice and cultural intelligence
- all interview panellists must be trained in the above training before being allowed to sit on a panel
- the implementation of an inclusive career development programme for staff in national 'agenda for change' bands 2-4 and 5-7.

13. Providers and commissioners should review and monitor their disciplinary procedures and panels to ensure the number of Black and Asian staff facing disciplinary is not disproportionate.

The Hertfordshire and West Essex Integrated Care Board is a new organisation, which has replaced three Clinical Commissioning Groups (CCGs) in Hertfordshire and west Essex. Data on disciplinary procedures was collected differently in the three organisations, and there were low numbers of staff overall involved in formal disciplinary processes in each CCG, making it difficult to draw reliable conclusions from the information available.

However, the ICB is in the process of amending our disciplinary policy to ensure that it supports a just culture, which does not disproportionately impact on staff from different backgrounds, protected characteristics, or ethnicities. If disparities are identified, our organisation will work to understand how these have arisen and to address any unfairness in our processes or bias in our staff. One change to the policy, which builds on national recommendations from Dame Dido Harding, is that a pre-disciplinary panel will be formed to review any incidents. The panel will take an independent view as to whether the disciplinary process should be enacted or if the matter may have arisen through cultural differences and/or to see if the matter can be resolved through other means such as training, mentoring, coaching or education for potentially the individual, the teams they work in or the organisation. This pre-disciplinary panel is made up of senior managers and would also ensure a consistent approach to potential disciplinary matters across the organisation.

14. Providers and commissioners should support Black and Asian staff to report experiences of discrimination or abuse from either fellow staff or patients, and provide ongoing wellbeing support.

We want all staff and board members to feel safe to 'Speak Up'. We expect all managers to 'Listen Up' and we require all Senior Managers, Directors, Non-Executive Members and Board Members to 'Follow Up'.

The ICB is committed to preventing harassment or victimisation of anyone raising a concern and does not tolerate bullying by others when a staff member raises a concern. Any such behaviour is a breach of our values as an organisation and if upheld following investigation could result in disciplinary action. The ICB has committed to increasing the number of staff 'Freedom to Speak Up Champions' who can support staff members either in the workplace, online, or externally. There is a named non-executive member sponsor for this work, and plans are underway to also assign an executive sponsor.

Anyone who works or has worked for the ICB or anyone who is working independently providing a service to the organisation can raise a concern. This includes students, temporary workers, agency workers, volunteers and governors.

Most concerns can be raised informally to line managers or another ICB manager, but staff can alternatively speak to: the ICB's Quality or Safety Teams, an Executive or Non-Executive director of the ICB, a Freedom to Speak Up Guardian, a Speak Up & Inclusion Champion, HR Manager or HR Equality and Diversity Lead.

In the light of the COVID pandemic which disproportionately affected people from some black, Asian and other minority ethnic communities, a confidential helpline was set up for NHS staff across our ICS area, including staff from the former CCGs, which was promoted explicitly to all staff from all black, Asian and minority ethnic backgrounds, in order to provide additional help and support with any issues from supportive allies.

There are a range of support services on offer to ICB staff, which are regularly promoted in staff briefings and publications. These include the Employee Assistance Programme, our 'Here for You' scheme, Mental Health First Aiders, online self-help resources and coaching.

15. Providers and commissioners should create a culture of equality and respect by encouraging ongoing discussions around race, culture and ethnicity.

Our ICB has a duty under the Equality Act 2010 to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Through the promotion of the East of England Anti-Racism strategy, the ICB has emphasised the importance of having open and proactive conversations around issues of race, culture and ethnicity.

Through our internal communications, we mark and celebrate events of cultural and religious significance to our diverse staff group, using these as an opportunity to foster understanding between colleagues.

The ICB's BAME staff network works to:

- positively challenge, input into, and support the organisation's equality diversity and inclusion activities
- support members to seek out career/leadership training and opportunities
- increase awareness of issues affecting BAME staff and wider population
- increase meaningful engagement with the organisation making the network a useful resource
- provide a voice for BAME staff within the organisation; using staff experiences, ideas and experience to help drive positive change
- support BAME staff, helping to meet cultural needs, support career progression initiatives
- support inclusion within the organisation generally

The network has helped to address vaccination hesitancy, input into the organisation's corporate action plan, WRES action plan and policies on EDI, bullying & harassment, increased awareness of issues affecting BAME population, co-produced region and system-wide inclusion activities, and led initiatives to amplify BAME staff voices within the senior leadership of the organisation and within the wider staff body.

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- Diversity and Culture Group
- Hertfordshire Asian Women Association
- Covid Recovery Ethnic Diverse Project